LONG-TERM CARE; AND PROPOSALS TO IMPROVE MEDICARE'S SKILLED NURSING FACILITY AND HOME HEALTH BENEFITS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

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CONTENTS

Page

Press release of Friday, February 22, 1991, announcing the hearing 2

WITNESSES

U.S Department of Health and Human Services, Health Care Financing Administration, Jeffrey G. Sanders, Director, Office of Legislation and Policy 42

Alzheimer's Association, Bill Keane 70
American Association of Homes for the Aging, John Selstad 81
American Association of Retired Persons, Margaret Dixon 54
American Health Care Association, Paul R. Willging 92
Ebenezer Society for Aging, Minneapolis, MN, John Selstad 81
First Choice Home Health and Personal Services, Inc., Columbus, OH, Fran Bäby 105
National Association for Home Care, Fran Bäby 105
National Committee To Preserve Social Security and Medicare, Max Richtman 68
Rowe, John W., M.D., Mount Sinai Medical Center, New York, NY 8
Wallack, Stanley S., Bigel Institute for Health Policy, Heller School, Brandeis University, and LifePlans, Inc., Waltham, Mass 16

SUBMISSIONS FOR THE RECORD

American Association for Counseling and Development; American Nurses' Association; American Psychiatric Association; American Psychological Association; Association for Retarded Citizens of the United States; International Association of Psychosocial Rehabilitation Services; Mental Health Law Project; National Alliance for the Mentally Ill; National Association of Developmental Disabilities Councils; National Association of Protection and Advocacy Systems; National Association of Social Workers Inc.; National Association of State Mental Health Program Directors; National Council of Community Mental Health Centers; and National Mental Health Association, joint statement 118
American Occupational Therapy Association, Inc., statement 121
Annunzio, Hon. Frank, a Representative in Congress from the State of Illinois, statement 124
Health Insurance Association of America, Linda Jenckes, statement and attachments 125
Manor Care, Inc., Silver Spring, MD, Stewart Bainum, Jr., statement 134
Massachusetts Medicare Advocacy Project, Diane F. Paulson, statement 139
National Association of Social Workers Inc., statement 140
National Council on the Aging, Inc., and the National Institute on Adult Daycare, Mary Ann Outwater, joint statement and attachment 143
On Lok, Inc., San Francisco, CA, Marie-Louise Ansak, statement 151

LONG-TERM CARE; AND PROPOSALS TO IMPROVE MEDICARE'S SKILLED NURSING FACILITY AND HOME HEALTH BENEFITS

MONDAY, MARCH 4, 1991

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to call, at 1 p.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
FRIDAY, FEBRUARY 22, 1991

PRESS RELEASE #3
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY PETE STARK (D.,CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING ON
LONG-TERM CARE AND PROPOSALS TO IMPROVE MEDICARE'S SKILLED NURSING FACILITY AND HOME HEALTH BENEFITS

The Honorable Fortney Pete Stark (D., Calif), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on issues pertaining to long-term care coverage and financing.

The hearing will examine comprehensive long-term care coverage proposals, including H.R. 651, the MediPlan Long-Term Care Act of 1991, and will focus on incremental proposals to improve Medicare's skilled nursing facility and home health benefits. The hearing will be held on Monday, March 4, 1991, beginning at 1:00 p.m., in room 1100 Longworth House Office Building.

In announcing the hearing, Chairman Stark said, "The need for long-term care is well documented. Now is the time for a national strategy to address the substantial needs of chronically ill individuals faced with the devastating cost of long-term care services. At the same time, there should be no delay in making necessary, incremental improvements in the Medicare home health and skilled nursing facility benefits."

Oral testimony will be heard from <u>invited witnesses only</u>. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

<u>BACKGROUND</u>

More than nine million Americans currently need long-term care services. The demand for long-term care services is projected to increase substantially. The increase is attributable in large part to improvements in longevity and the projected growth of the elderly population--particularly individuals ages 85 and older who are most likely to need long-term care services.

Long-term care expenses are beyond the resources of most American families. The average cost of a nursing home has increased to nearly $36,000 per year. The price of home care services for the severely impaired person can easily exceed $14,000 per year. Few can afford the staggering costs of long-term care.

Public financial support for long-term care is limited. Private out-of-pocket payments account for 50 percent of total national nursing home expenditures. The Medicare program finances less than two percent of total nursing home costs. Medicaid covers nearly half of the nation's $43 billion nursing home bill, but limits coverage to the poor.

The Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) included two provisions that would have expanded Medicare's home health and skilled nursing facility benefits. Both provisions were subsequently repealed in the Medicare Catastrophic Coverage Repeal Act of 1989 (P.L. 101-234).

(MORE)

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Monday, March 18, 1991, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

Chairman STARK. Good afternoon.

This afternoon the Subcommittee on Health will begin a broad overview of long-term care issues. We will then move on to discuss incremental improvements in the Medicare home health and skilled nursing facility benefits.

We have yet to establish a national long-term care strategy. As a result, the fear among the seniors of losing their assets due to long-term internment is still with us. The need for long-term care has been well documented.

Last year the Pepper Commission issued a comprehensive report which included the extensive description of long-term deficiencies in this country. Unfortunately, there is less consensus concerning how these needs can best be addressed.

Earlier this year, I introduced H.R. 651, The MediPlan Long-Term Care Act of 1991. This bill provides a blueprint for comprehensive reform and incorporates the five critical features of a national long-term care plan.

All chronically-ill individuals, regardless of age or income, would be eligible for benefits; all individuals would have true protection from financially devastating long nursing home stays; the full range of long-term care services would be covered to provide the most appropriate level of care; benefits would not be means-tested; the financing would be progressive and astronomical. It would cost $60 billion a year.

As a method of getting the discussion going, I suggested we put a flat tax on all incomes above 200 percent of profit, which ought to at least generate a modest amount of discussion.

Nonetheless, the bill was intended to do just that, to make it completely comprehensive to protect, unlike the Pepper Commission, the long-term nursing home or home health care needs rather than the first or first couple of months as the up-front benefits.

We will focus today, in addition to long-term care on incremental improvements, on Medicare home health and skilled nursing benefits.

Last week, Mr. Moody, Mr. Cardin, Mr. Coyne and I introduced H.R. 1200. This bill would clarify that home health services would be covered on a daily basis, up to 7 days per week, for a period of 38 days, and would eliminate the 3-day prior hospitalization rule for skilled nursing facilities.

These provisions were originally included in the Medicare Catastrophic Coverage Act of 1988, and were subsequently repealed one year later.

I am quite disturbed by the absence of a national consensus in the area of long-term care reform. Without such leadership, it will be extremely difficult for the Congress to enact a comprehensive long-term care plan.

In the meantime, the subcommittee will continue its efforts to make modest improvements in the Medicare program in order to provide critical services for our nation's seniors.

I look forward to the testimony of our witnesses this morning.

Thank you.

[The opening statement follows:]

Opening Statement

The Honorable Pete Stark

Hearing on Medicare long-term care, skilled nursing facility and home health issues

Good afternoon. This hearing of the Subcommittee on Health will begin with a broad overview of long-term care issues. We will then move on to discuss incremental improvements in the Medicare home health and skilled nursing facility benefits.

This country has yet to set forth a national long-term care strategy.

As a result, the fear of a long and costly nursing home stay creates great anxiety among seniors and their families. Many seniors worry -- with justification -- that a long-term chronic illness will force them onto the welfare rolls or make them a financial burden to their children and grandchildren.

The need for long-term care has been well documented. Last year, the Pepper Commission issued a comprehensive report which included an extensive description of long-term care deficiencies in this country.

Unfortunately, there is less consensus concerning how the nation's long-term care needs can best be addressed.

Earlier this year, I introduced H.R. 651, The MediPlan Long-Term Care Act of 1991. This bill provides a blueprint for comprehensive reform and incorporates the five critical features of a national long-term care plan.

* First, all chronically ill individuals, regardless of age or income, would be eligible for benefits;

* Second, all individuals would have true protection from financially devastating long nursing home stays;

* Third, the full range of long-term care services would be covered to provide the most appropriate level of care;

* Fourth, benefits would not be means-tested;

* Fifth, the financing would be progressive.

Because the proposed program would be comprehensive, the benefits are estimated to cost some $60 billion when fully implemented. Revenues would be raised by a tax on gross incomes -- with an exemption for individuals with incomes below 200 percent of poverty. This proposal meets the test of raising sufficient revenues to cover the benefit package.

Today's hearing will also focus on incremental improvements in Medicare's home health and skilled nursing facility benefits. Last week, Mr. Moody, Mr. Cardin, Mr. Coyne and I introduced H.R. 1200. This bill would clarify that home health services would be covered on a daily basis, up to seven days per week, for a period of 38 days and would eliminate the 3-day prior hospitalization rule for skilled nursing facilities.

These provisions were originally included in the Medicare Catastrophic Coverage Act of 1988 and were subsequently repealed one year later.

I am quite disturbed by the absence of Presidential leadership in the area of long-term care reform. Without such leadership, it will be extremely difficult for the Congress to enact a comprehensive long-term care plan.

In the meantime, the Subcommittee will continue its efforts to make necessary improvements in the Medicare program to provide critical services for our nation's seniors.

I look forward to the testimony of our witnesses this morning.

Chairman STARK. Mr. Gradison.

Mr. GRADISON. Thank you.

I, too, look forward to our witnesses.

I want to congratulate you for introducing the legislation to which you refer.

Not that I am supporting it, but you indicated how you would pay for it, which is a refreshing change from many of the suggestions we get here from time to time about how to spend the taxpayers' money.

One thing that has not been said as clearly as I think it should be said, for many supporters of greater national action to the long-term care field, the Budget Enforcement Act of last year was a setback.

It picked up the increased revenue from increasing the tax base for the hospital insurance trust fund to $125,000 without earmarking it, obviously, for long-term care.

A number of those who would have been active in promoting the greater federal involvement in this field, much greater than I certainly would support, including our old friend from Florida, the late Claude Pepper and the Senate Leader George Mitchell, had in their legislation planned to use that increase in the HI base to pay for long-term care. That is gone.

In that respect, I refer to last year's legislation as a setback, in the sense it is necessary to go back, for those who want to spend money in those quantities, to go back to the drawing board and figure out some other way to fleece the taxpayers.

Thank you.

Chairman STARK. Mr. Moody.

Mr. MOODY. Thank you.

I agree with the gentleman that it was a major departure. The Administration broke the ice on raising that ceiling. We did it one better by taking it up to 125.

Mr. Chairman, I appreciate the chance to participate in this morning's hearing.

I salute you for introducing this bill to repeal the 3-day hospitalization waiting period, which I had a bill in last Congress to do, and to increase home health care to 38 days.

I hope the witnesses today would help us distinguish between the issues of health care on the one hand and asset protection on another.

In many respects both the catastrophic health care bill whose demise I personally mourn, and a number of proposals for long-term health care have one important feature, namely, they are as much asset protection as they are health measures.

They prevent people from being wiped out as a result of unexpected or very large expenditures. In that regard, I hope the gentleman, and other witnesses will address the issue of how we best finance it. If, for example, it is three-quarters asset protection and one-quarter health care coverage, should it not have an asset-related financing basis, since it is protecting larger assets for wealthier people?

To ask someone to pay the same premium for long-term care regardless of their wealth would be like asking two families to pay the same for fire insurance.

One is insuring a mansion, and the other is insuring a shack.

I hope the gentleman and other witnesses will address those matters.

Thank you, Mr. Chairman.

Chairman STARK. You are welcome.

Rarely do I admonish distinguished Members of the subcommittee to pay attention.

I will admonish the gentleman. Had he been here at the beginning of my statement, he would have heard me give him deep credit for H.R. 1200.

Second, in the past years I would say even one-quarter is too low. It is the Chair's opinion that long-term care is not a medical problem at all.

It is a question of rich people. Arguably people as rich as Members of Congress with pensions as generous as ours don't need long-term coverage.

We have enough money to keep us in the best nursing homes forever without affecting our assets or our children. It is the vast majority of Americans who are not as generously provided for as we, who just need money.

Our first panel, is comprised of Dr. Rowe, president and chief executive officer of Mount Sinai Medical Center in New York, professor of geriatrics and adult development in the school of medicine there.

He has had a longstanding interest in aging issues and is serving as the director of the MacArthur Foundation, Research Program on Successful Aging.

I should say issues that affect the aging, not aging issues, had I paid more attention when I was in school.

He is sharing the stage with Dr. Wallack, director of the Bigel Institute for Health Policy of the Heller School at Brandeis University. He is also chairman and CEO of LifePlans Inc.

We welcome both of you gentlemen here.

In order to give us time to inquire, we have your prepared statements here in their entirety.

Without objection, the prepared statements of all witnesses today will appear in the record in their entirety.

We would ask you to summarize or expand on your written statements in 5 to 7 minutes, and then see if we can review them with you at that time.

Dr. Rowe.

STATEMENT OF JOHN W. ROWE, M.D., PRESIDENT, MOUNT SINAI MEDICAL CENTER, NEW YORK, N.Y.

Dr. ROWE. Thank you.

It is a pleasure to be with you today and to share your time with my distinguished colleague, Dr. Wallack.

I think some of these issues are aging issues, Mr. Stark, they have been around so long. Hopefully, the time has come to make progress on them.

I speak from my experience as president of a large urban academic medical center, as you mentioned. Last year Mount Sinai

had over 9,000 Medicare discharges—and also an academic geriatrician.

I have published over 100 scientific papers in geriatrics and served as the chairman on the Committee on Geriatrics of the National Academy of Sciences.

The time for substantive reform of our long-term care system, one of our most flagrant national embarrassments, may finally have come. Eight of ten voters are now personally familiar with the problems of obtaining and paying for long-term care and list financing of long-term care as one of their top concerns. This is regardless of whether they are Republican or Democrat, or identify themselves as liberal or conservative.

There is now general agreement on the goals for reform, though persistent disagreement regarding its specific details and, of course, the sources of support.

No one, providers, patients, families, regulators, or policymakers is satisfied with the current status of long-term care. Long-term care is a system of health, social, and importantly personal care, not just health care, to support people who have chronic or long-term physical or mental disabilities, of which there are over 9 million in the United States.

Two-thirds of these individuals are elderly. Contrary to public belief, most of these people do not reside in long-term care facilities.

Our problem is going to get worse. Our elderly populations is growing very rapidly.

A study published just this week in the New England Journal of Medicine, predicted 43 percent of the people who turn 65 this year will spend some time in a long-term facility. Roughly, one half of Americans who are now turning 65 will spend some time in a nursing home.

Chairman STARK. Are we going up or going down?

Dr. ROWE. It is about the same as it has been for the last decade. The number of people in nursing homes is going up dramatically because of the number of people 65 and older is increasing.

Few can afford the costs of long-term care. The average annual nursing home expenditures range from $25,000 to $40,000.

Unless you are in New York, of course, where the dollars are smaller, you have to change your American dollars to New York dollars when you get to the airport in New York.

It costs $75,000 of those dollars if you are in a nursing home in New York. If you can't afford that, your home care services, particularly if you have Alzheimer's disease, exceed $15,000 a year.

Who pays for this? Half is paid out of the pockets of American families and the patients.

The other half is covered by the Federal Government via Medicare and by State governments via Medicaid. Medicare is generally an acute-care program. It pays only a very small portion of long-term care expenses, though 70 percent of old people in the United States are not worried about nursing home care because they think Medicare is going to cover it. Medicare is the epitome of the American health care system.

We have an acute-care system designed to take care of acute illness in young people. In this system we have previously unima-

gined numbers of chronically ill elderly individuals who are trying to find their way through this system designed to take care of acute illness in young people.

Several points are often overlooked in the interesting congressional debate about long-term care, which tends to focus more on dollars than on patients.

As an academic geriatrician and clinician, I would like to talk with you for a minute about the patients.

First of all, the long-term care population is very, very heterogeneous. It includes people with a wide range of ages, diagnoses, medical conditions and prognoses.

If you have seen one fragile old person, you have seen one fragile old person. And you have not seen a representative of the geriatric population.

Some of our elderly patients are able to remain home or return home shortly after entering a nursing home. Others are physically sound, but demented and spend long periods of time, often several years, in nursing homes. Still others are fragile with multiple coincident diseases and require frequent admissions to the hospital.

Second, the population leaving hospitals for nursing homes is sicker now than it was several years ago.

Third, not all disabilities are progressive. I think this is really important and underlines the policies that I would recommend that you change.

Substantial data indicate that many functionally-impaired older persons improve in their functional status. Older people can get better with home care, in a long-term care facility and they can be less dependent and they can return to more autonomy.

I couldn't be the President of a medical school if I didn't ask you to support more research. With very few notable exceptions, the only time a medical researcher goes to a nursing home is to visit his grandmother.

Just this past week a study in the Journal of the American Medical Association found that patients in nursing homes have undetected depression to an alarming number and that depressed patients in nursing homes have a sharply higher risk of dying.

Add this to the well-known fact that depression in the elderly is easily treated. We need much more research on illnesses in nursing homes.

A few specific suggestions for you, as I close. The need for long-term care reform is obvious.

The solutions are difficult, particularly with the budget aggravated by the savings and loan bailout and the Gulf War. Specifically, I suggest the following: First, our goal should be to establish a comprehensive social insurance program for long-term care.

Regardless of whether such care is provided at home or in a nursing home, public financing should initially be focused on the longer stays to prevent impoverishment, leaving a significant role for private long-term care insurance for those who can afford it, although I recognize the potential downsides of that.

Short of implementation of that policy, I suggest, on the margins of current Medicare policy, that this year you provide increased Medicare coverage in skilled-nursing facilities to 180 days—restoring the coverage initially included in the Catastrophic Care Act.

Additionally, the current requirement for three-day hospitalization prior to eligibility for skilled nursing facility benefits should be repealed. As a clinical geriatrician, I view this restriction as counterproductive.

The home health care benefit is intermittent for home-bound elders and should be revised to provide one month of consecutive days for disability. The current approach which funds services which are only intermittent is clinical nonsense.

If you take a sick old person and treat them 5 days in a row to improve his function and then you don't treat him for 2 days, he may slide back half way to where he was when you started. Then you come back and you start over again. It doesn't make sense.

Third, the home health care component of Medicare should be expanded to cover personal care, attendant, homemaker, and chore services. The reason for that is while it may appear to be more expensive, it is actually, I believe, less expensive because of the well established relationship between functional impairment and re-institutionalization.

Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF JOHN W. ROWE, M.D., PRESIDENT, MOUNT SINAI MEDICAL CENTER

Mr. Chairman and Members of the Subcommittee:

I am John W. Rowe, President of the Mount Sinai School of Medicine and Mount Sinai Hospital in New York City. Thank you for this opportunity to discuss long-term care with you this afternoon.

I speak to you from my experience as president of a large urban academic medical center which had over 9000 Medicare discharges in 1990, and which is affiliated with a major long-term care facility as well as a VA facility, and as an academic geriatrician. I have served as professor of medicine and the founding director of the Division of Aging at the Harvard Medical School. I am the immediate past president of the Gerontological Society of America, have authored a major textbook of geriatric medicine, and have published over 100 scientific papers in geriatric medicine. I have served as chair of the Committee on Academic Geriatrics of the National Academy of Sciences and as a member of the Commonwealth Fund Commission on Elderly People Living Alone which has issued numerous reports.

The time for substantive reform of our long-term care system may have finally come. While considerable disagreement persists regarding the specific details of reform, and the sources of the funds to support it, there is now general agreement on the goals for reform and the political will may now finally be present to revamp one of our most persistent and most flagrant national embarrassments. As more American voters and policymakers personally confront problems of long-term care with parents, spouses and other loved ones, the issue has moved to the front of the political agenda. Surveys during the 1988 presidential election showed that eight out of ten voters are personally familiar with the problems in obtaining and paying for long-term care and that financing long-term care is one of the top concerns of voters, regardless of whether they are Republican or Democrat, liberal or conservative.

No one -- providers, patients, families, regulators, policymakers -- is satisfied with the current status of long-term care.

Let me begin with a few facts:

- What is long-term care? Long-term care is a system of health, social and personal care services to support people who have chronic, or long-term, non-remediable physical or mental conditions.

- Who needs long-term care? Between 9 to 11 million chronically disabled Americans are dependent on others for assistance in the basic tasks of daily living and require long-term care. Two-thirds of this population are elderly. The vast majority live in the community. Contrary to wide-spread belief, long-term care does not mean only nursing home care.

- o As you all know, our elderly population is growing very rapidly. There are already over 30 million older Americans, representing over 12% of our population and by 2030, there will be 66 million, comprising 21.8% of the population. The most rapidly growing group, those over age 85, will increase most dramatically, and this is the group that most requires long-term care.

- o Almost one out of two Americans will require some long-term care services at some point in their lives. Although it is often said that on any given day, 5% of the elderly are in nursing homes, this is misleading. Estimates are that 36% to 45% of people age 65 and over will spend some time in a nursing home before they die. With the increase in the over-65 population, the need for long-term care will be even greater.

- o Few can afford the costs of long-term care. Average annual nursing home expenses range from $25,000 to $40,000. In the New York City area, annual expenses can be as high as $75,000. Home care services to help care for a severely impaired Alzheimer's patient can exceed $14,000 per year.

Who pays now for long-term care? Fifty percent of long-term care expenses come out of the pockets of the patients or their families. The other half is covered by the government. Medicare -- originally intended to keep illness from destroying an elderly person's savings and to ease the financial burden on families -- is generally an acute care program and pays only a very small portion of long-term care expenses.

Medicaid, which pays for almost 90% of the public financing for nursing home care, is a payor of last resort. Disabled people with incomes and resources low enough to qualify for SSI assistance are eligible for benefits; others qualify only by spending down their assets and income on the cost of care before they become eligible for Medicaid. Just over one-third of nursing home users receive Medicaid when they enter the nursing home and another 10 to 16 percent spend down their assets during their stay. This impoverishment -- the so-called Medicaid spend-down -- is as un-American as anything you will hear about in this committee. Severe restrictions in Medicaid reimbursement have limited the quality of long-term care provided to beneficiaries in many areas, and act as a continuing disincentive to expansion of the available long-term care beds, despite the fact that demand already exceeds supply -- a condition that will surely worsen. In sum, the Medicaid program provides inadequate support for limited access to marginal quality long-term care.

What are the reasons for the poor quality and neglect in this area? I would like to suggest the following:

1. Prior abuses in the nursing home industry.

2. "Ageism", lack of interest on the part of health care providers and organized medicine, in care of the frail elderly.

3. The erroneous linkage between regulation and quality. Access to care is severely limited, in part, because federal and state regulations have multiplied and become more stringent over recent years. This has driven down private sector interest in long-term care. In addition, special requirements for nursing home design and construction -- and the prohibitively high cost of such construction -- have resulted in an inadequate supply of nursing home beds. The Nursing Home Reform Act, while well-intentioned, failed to provide adequate resources to implement the new mandates. There must be greater regulatory flexibility.

Several points often overlooked in the long-term care debate, which tends to focus on dollars rather than patients, need to be emphasized.

First, the long-term care population is very heterogeneous -- it includes people with a wide range of ages, diagnoses and medical conditions. If you've seen one frail old person, you've seen one frail old person. Some are able to remain home, or return home after a short nursing home stays; others are physically sound but suffer from debilitating dementia, such as Alzheimer's Disease. Still others are frail with multiple coincident diseases and require frequent admissions to the hospital. We need a system that will serve the needs of each group.

Second, the population entering nursing homes is now more acutely ill, partially as a result of efforts to shorten hospital stay, and require a greater level of care in the nursing home.

Third, one cannot address long-care care without addressing the health care personnel shortage, especially the nursing shortage. Given an option, most nurses choose to work in the acute care setting rather than in nursing homes, in part because of higher salaries. Home care and personal care aides are notoriously underpaid. Too few physicians are trained in geriatric medicine -- about the only time a medical resident is in a nursing home is to visit his or her grandmother. More emphasis must be placed on geriatric medical education.

Fourth, we must force more focus on rehabilitation, on returning people to their homes or other non-nursing home settings. For this reason, resources need to be focused on the front-end of the nursing home stay to help people recover before the window of possible recovery closes, not just the back-end, to limit the ultimate financial impact of long-term nursing home stays, some of which could have been prevented.

Finally, there must be more emphasis and resources devoted to research aimed at preventing, delaying and dealing with long-term illnesses and disabilities. With few very notable exceptions, medical investigators rarely conduct research in a nursing home. A study published just last week in the Journal of the American Medical Association found that many patients in nursing homes have undetected depression and that severely depressed patients in nursing homes have a sharply higher risk of dying over the course of a year than other nursing home patients. Depression is a very treatable disease in older persons - the key is to recognize it is present. This is just one example of how research could improve the status of elderly patients and perhaps limit nursing home stays for many.

The need for long-term care reform is obvious. Unfortunately, the solutions are not easy, especially in the face of the overwhelming budget deficits which confront us at the federal, state and local levels.

I commend you, Mr. Chairman, for sponsoring today's hearing and for your important contributions to the national debate on long-term care, and thank you again for inviting me to address the subcommittee. I would be happy to answer any questions you or other subcommittee members might have.

Dr. ROWE. I would like to commend you for sponsoring today's hearing and for your important contributions to national debate on long-term care.

Chairman STARK. Thank you.

Dr. Wallack.

STATEMENT OF STANLEY S. WALLACK, PH.D., DIRECTOR, BIGEL INSTITUTE FOR HEALTH POLICY, BRANDEIS UNIVERSITY, BOSTON, MA, AND CHAIRMAN AND CHIEF EXECUTIVE OFFICER, LIFEPLANS, INC.

Mr. WALLACK. Thank you.

We are not in a great deal of disagreement about some of the problems, Dr. Rowe and I. The financing approach I will talk about is quite a bit different.

I think the discussion this committee has talked about, particularly the extension of the benefits, home care, dropping the 3-day prior institutionalization is really about the nexus between acute and long-term care.

In doing that, the population that straddles both systems, you are going to have to deal with the deficiencies of the acute care systems and deficiencies in the long-term care system. I think we need to keep them separate.

I want to talk about doing a lot more with fewer federal dollars. I think it is possible. That is going to take leadership.

It is the kind you talk about, Mr. Chairman, with a consensus, but government leadership is what I think we have to do to motivate the private sector.

In the acute care side I see it differently from the long-term care side. This is where we need to motivate system change by dealing with financing and organization. We need serious systematic reform there.

When we move to long-term care, it is a very different issue. Much of the problem we are looking at is asset protection.

There, I think we have to find a way to motivate the private sector, both individuals to protect their assets, and providers of insurance to meet that need as well.

I as well as Dr. Rowe have had a long experience in this field. I started thinking about this issue 15 years ago when I was with CBO.

I commend you for having those hearings.

At that time I looked at the catastrophic expenditures of the elderly. When I went to Brandeis, one of the concepts we developed is the social HMO, an attempt to integrate Medicare with some long-term care benefits.

To me the social HMO is an improvement in the Medicare program. It brings an expansion of benefits that makes sense for the acute care of the older population.

In addition to that, a few years ago I took a sabbatical from Brandeis and started a private company to work with private insurers in long-term care. The idea was to work and develop a national network of local care management organizations so we could do a better job in underwriting, a better job in care managing disabled older individuals.

Thus I have been looking at the issue of concern for a number of years from the acute care side and the long-term care side. I have some lessons I hope to share with you today.

The population we are talking about, the population that needs some long-term care services is a very diverse population, as Dr. Rowe said. My own research at Brandeis shows the probability of people needing nursing home care was around 40 percent. That is the probability over one's lifetime was about 40 percent.

A key point is more than half of these people, about 60 percent, need less than 6 months of such care. Most of those stay less than 3 months in a nursing home.

Then you find a smaller percentage, 10 to 15 percent of the people actually end up, about one quarter of those enter a nursing home, staying more than a year. That 10 or 15 percent of people spend 90 percent of the nursing home dollars.

It is important that we separate, as we look at long-term care, those who are short stayers, they often have an acute care problem. They are in there because they are bedridden. Short-term stay individuals are also terminal patients.

The long-term patients, the ones with functional and cognitive impairments, are the long stayers. We need to separate these two populations as we look at the appropriate financing.

Long-term care stayers have catastrophic expenditures. It is almost impossible for any individual to pay these costs.

The real question is what is the appropriate kind of public and private financing approach that makes sense?

Now I think in asking that, we need to—and, hopefully, this is the right time to do it over the next few months—think what is the appropriate public role and private role?

Should we have a public program with a private sector filling the gaps or should we look to a private program with, in fact, the public sector coming in to fill the deficiencies that the private sector cannot really solve?

Answering that question, I think you have to say is it reasonable to start off and look at what the private sector can do and is it preferable?

Reasonableness, it would seem to me, would depend upon whether there is, in fact, a private market out there. When I first did my work at CBO there was no private long-term care insurance market. There was market failure. Today, there are many active private insurers.

It is true if you look at the cost of long-term care, it is 80-year-olds who have—a huge percentage of them are the long stayers. If you wait until people are 80, there is no doubt they will have to be funded publicly. With private insurance the idea is to prefund, to start earlier and build up a reserve so in they can pay for long-term care later.

It seems to me, we should look at how many people could potentially afford to pay private long-term care insurance even if they wait until they are 65 years of age. We have done some work on this issue.

The consensus may be building that maybe a third, 30 percent, 40 percent, my own work says 40 percent potentially of the over 65 population, could afford a private long-term care insurance policy.

Obviously, there is over half that can't. We need to have some kind of public and private financing system. The question is what and which one makes sense?

In a study LifePlans did evaluating the different kinds of financing options, social insurance programs, targeted Medicaid programs, tax incentives, I think the results are important to the deliberations of this committee.

When you look at a social insurance program, one of the more important things is who benefits from that program. Our work has shown in the social insurance program that, roughly, 70 percent of the benefits would go to those people today who could buy a private long-term care insurance policy.

New additional dollars would go to those people who could afford a private policy. The reason for that is simple when you think about it it is not very difficult. Medicaid is a very well-targeted program. It reaches those people who really cannot afford their own care.

Chairman STARK. I will give you extra time.

Does the 70 percent go to those who can afford it? Are you integrating that with Medicaid?

Mr. WALLACK. Yes. This is a model which we would share with some committees and with the department and we are willing to share it with the CBO. It is a model which looks to the total expenditures and then looks at the distribution of who benefits.

We look at the total addition, let's say it is $20 or $40 billion, then we estimate who receives those benefits.

In my written testimony I am sharing with you some of the results. Basically, it is the additional dollars, and where those additional dollars go.

If you spend $20 billion, 70 percent of those additional dollars would go to those people above $15,000 in income. A third would go to those above $30,000 in income.

Chairman STARK. None would go to those who currently qualify for Medicaid?

Mr. WALLACK. Low-income would, obviously, benefit as well. More so in a program that emphasizes the front end dollars because they would benefit.

The fact is people spend down and they, therefore, go on Medicaid. Any program that picks up the tail would only benefit higher-income people.

If you look at sources of the potential financing stream, I think you move to Mr. Moody's question. If that is true that what we are looking at is a great deal of asset protection, the question is how to finance that program.

I gave you in my testimony a chart which shows the proportion of dollars different kinds of taxes would generate by age. If you went with a FICA tax, a wage tax, if you assumed only those over 65 benefitted from long-term care, they would pay three cents for every dollar they receive in benefits; if you do an income tax, it is around 14 cents. Asset tax is about 45 cents. The elderly have more income and more assets. The distribution effects are different, if you are looking at a nonsocial program to solve this problem.

I think a reasonable strategy, given the financing problems we are talking about, is an enhanced Medicaid program. A small en-

hancement of Medicaid of relatively a few billion dollars would start to get at that population now spending down.

If you went and increased the asset level for Medicaid from $2,000 to $12,000, you would be able to, in fact, get at 50 percent of the people that are now spending down under Medicaid. That is a population we would like to protect because there is potential they could return home, as Dr. Rowe said.

These people do recover and they end up staying in these institutions just too long. I do believe there are significant Medicaid enhancements that can be made for relatively few dollars.

If you go with a Medicaid strategy and say those who can insure themselves should, will they do it? If you look at the current market, I am actually very disappointed. Whereas I believe 40 percent of the current population can afford to buy a long-term care population, roughly 3 or 4 percent are doing that.

There is tremendous confusion out there. There is tremendous confusion whether Medicare is going to pay. There is real disdain out there because they hear horror stories about private long-term care insurance. If the long-term care insurance is to develop, if the private market is to develop, the government must take a leadership role.

The elderly population, in particular, look to the government. Their government really sets the tone, sets the environment from which they will follow. If we want to support a long-term market, if we want to come near the potential, in fact, the government is going to have to find a way of being supportive of that.

The other major area, one that comes back to the short-term stay focus of this testimony, is for the government to set a long-term care strategy by improving Medicare. Rounding out Medicare and improving its benefits would probably do more to improve the long-term care market.

By improving Medicare, what is remarkable is roughly 70 percent of the elderly have some kind of medigap protection. It is first dollar protection. When we look at Medicare and medigap combined, we see a market and the program itself as an unmanaged system with overlapping financing which results in overconsumption and unnecessarily high Medicare expenditures.

One of the things the social HMO does is to develop a more well-rounded benefit package. The social HMO also dealt with reforming the organization and the financing of care.

What the social HMO does is provide more benefits, prescription drugs, home health. It fills out the hospital side and the physician side. It does all of that with Medicare paying no more money and the individual paying a premium less than the prevailing medigap. We do that and we successfully do that because, in fact, with a managed system, we are able to reduce hospital days.

In this country, now, the Medicare population has about 3 days of hospital care per person. In the social HMO projects, as well as other HMO's, it is around two days per person. If you save one hospital day per person, it is $700. You can do an awful lot with regards to home health care, short-term nursing home care for $600 or $700.

The social HMO teaches us the importance of linking the financing and of organizing and managing care. There are many other

models. The last Congress actually asked for an expansion of new social HMO models, from the administration. I think those can be very exciting and much more broad-reaching.

Let me conclude. I have been really suggesting that one way to proceed to develop a long-term care strategy is reforming Medicare. A Medicare strategy need not cost many new additional dollars. What would happen if the government would decide to do these expansions on Medicare, the appropriate expansions for this population is that the government would be taking a leadership position in finding the boundaries between long-term care and acute care.

It would also be sending a real signal out there to the general population that the short-stay is Medicare's major responsibility and there is potentially a private sector responsibility with regard to long-term stays.

What I have been suggesting, I have not priced out all of this, but it is not very much money relative to the $40 or $50 billion that this committee is thinking we need to solve this problem. What it would be is leadership.

This is what I think the Federal Government needs to provide: Leadership's health and long-term care planning and thinking about how we should finance and organize Medicare and also leadership with regard to the private long-term care system.

I think in conclusion, that it is very important that we find a way for the public sector to guide the system, to talk to the leadership and really to motivate the private sector to achieve public goals. If you think of long-term care, what we are talking about is educating the population to protect their assets. We would also be working to educate the private industry to produce the kinds of long-term care insurance products that provide adequate consumer protection and are in the public's interest. It is leadership that will yield major changes, not more dollars.

Thank you.

[The prepared statement follows:]

STATEMENT OF STANLEY S. WALLACK, PH.D., DIRECTOR, BIGEL INSTITUTE FOR HEALTH POLICY, HELLER SCHOOL, BRANDEIS UNIVERSITY; CHAIRMAN AND CEO, LIFEPLANS, INC., WALTHAM, MASS.

I appreciate the opportunity to testify today before the Subcommittee on Health of the House Ways and Means Committee on the health and long-term care needs of the elderly and the need for program enhancements. The focus of these hearings is on the nexus of acute and long-term care needs in that the Committee is discussing expansions in home health benefits and the elimination of prior hospitalization for nursing home benefits. An important issue that will undoubtedly be addressed is how to efficiently and cost effectively manage the needs of individuals who span both these categories.

The deliberation of this Committee will undoubtedly include both the limitations in the current Medicare program as well as the inadequate financing of long-term care. I have been actively engaged in both of these issues over the past 15 years. Because of the deficiencies in Medicare benefits and, more importantly the need to bring greater efficiency to the acute care system, Bigel Institute developed and implemented the Social/HMO program. The S/HMO merges financing and delivery permitting the care of the elderly to be managed more efficiently and comprehensively.

My own efforts in addressing the financing of long-term care go back to my time at the Congressional Budget Office in the mid-1970's. At that time there were no private sector alternatives. This has certainly changed. There is also the realization that through risk pooling individuals can protect themselves against out-of-pocket costs. In 1987, I started LifePlans, Inc., to work with private insurers on means of expanding the benefits provided under their long-term care insurance programs. LifePlans, through it's national network of community geriatric agencies, The Family Caring Network, provides assessments and assistance to insured elderly that need long-term care services.

I believe my experience with the S/HMO and private long-term-care insurance plans have provided me with insights into the importance and need for an increased governmental role in addressing the health and long-term care needs of the elderly. I believe, however, the major activities needed in these sectors is quite different. While the government must direct system reform in acute care, the major new challenge for the government in long-term care is to guide the private sector.

My testimony today will focus on the possible roles for the federal government in financing of care for the elderly. In a period of limited resources this Committee will be struggling with the additional costs of incremental changes. In my view government can achieve a great deal in providing adequate access and quality acute care and meet long-term care needs for relatively little additional dollars. This requires making significant policy changes in the way we finance and manage acute care services. Making such changes will require leadership, leadership that only the government can provide, to define the boundaries of acute and long-term care as well as the acceptable financing and organizational arrangements. I believe that by enhancing and improving Medicare the federal government will be taking, perhaps, the most important step in allowing the private long-term care insurance market to fulfill it's potential role in solving a major social problem -- the financing of long-term care.

1. The Impact of Long-Term Care Needs

While I am going to end my testimony discussing the way to improve Medicare, I want to begin with the problem of financing long-term care services. As we all know, this has become an important social problem facing the nation today and one that only will grow in the future.

With Medicare paying for most acute health care costs, long-term nursing home and home and community care costs have become the major catastrophic expenditure faced by the elderly. A single year in a nursing home can cost more than $25,000 and nearly two in five individuals over age 65 will spend at least some time in a nursing home during their remaining life. For this population about 50 percent of these expenditures are paid for by the recipients of care or their families.

The use of long-term care services and the distribution of costs varies greatly. The distribution of lifetime nursing home costs for those in the 65-74 age group is presented in Table 1. The lifetime probability of entering a nursing home for the over age 65 population is approximately 40 percent, and, of these, the majority stay less than one year. As a result of this distribution of use, about 15 percent of the population account for 90 percent of expenditures, and the four percent that stay for more than five years account for approximately 50 percent of the expenditures. A very important observation to keep in mind is that the population of nursing homes is made up of two populations: the short stayers, about 50 percent leave in six months or less and the long stayers, the 13-15 percent that account for 90 percent of the dollars. The short stayers are often in a nursing home as a result of an acute episode: temporarily bed ridden, recovering from a fracture or being in a late stage of cancer. The long-stayers are more likely to be there because of functional loss and alzheimers.

When a small percentage of people face a high probability of incurring a large expenditure, risk-spreading or insurance is an attractive option. With all individuals in an age group paying an equal amount, the catastrophic costs for a few could be avoided. Both public policy options and the growth of private long-term care polices identify insurance or risk spreading as the preferred option. However, the prevalence of nursing home and home and community care use rises significantly with age. The need for long-term care is derived from the loss of the functional ability to care for oneself.

Personal care needs rise dramatically with age. These are shown in Table 2. For the over age 65 population, less than five percent are in a nursing home at any time. However, about one percent of those 65 years of age, five percent of those 75 years of age, and more than 20 percent of those 85 years of age are in nursing homes. If the financing is done on a pay as you go basis, the vast majority of dollars will have to be public since a very small percentage of individuals over 80 have the means to pay for care. However, private long-term care insurance, which relates premiums to age of issue, builds up a fund to pay for future cost. Thus, private financing avoids large inter-generational transfers.

The current means of financing long-term care -- state Medicaid programs and individual out-of-pocket payments -- leave middle income elderly in a position of having to make hard choices when seeking long-term care services. They can pay out-of-pocket for the services, make arrangements to receive services from families or friends, divest their assets to qualify for Medicaid, or finally go without the necessary care. Escalating costs, questionable adherence to quality standards and access problems have led to an increasing demand for a new approach to financing long-term care. Recognition of this is now wide spread both in the public and private sectors.

2. Public and Private Financing Roles

The government currently pays for roughly one-half of all long-term care expenses, primarily through the Medicaid program and other government programs.

Recently, there have been a number of proposals and recommendations for public action relating to new approaches in financing long-term care services. The myriad and divergent legislative proposals now being considered are evidence that a consensus on the public role has not yet emerged. In general, proposed public approaches fall into three major categories:

(1) Social Insurance for all or part of long-term care.

(2) Stimulation of the private market through tax clarifications, subsidies, and education.

(3) A targeted public approach building upon the Medicaid program.

Over the last five years, private sector involvement in financing long-term care has grown considerably. In 1989, over 100 insurance companies were writing long-term

care insurance policies and about 1.5 million policies had been sold to more than 4 percent of the elderly population. Between 1988 and 1989 alone, long-term care insurance policy sales increased by about 35 percent. Moreover, activity in the employer-group market has been increasing steadily with a number of major firms committed to offering plans to employees as part of their benefit package.

The private and public sector roles will continue to evolve and develop. Private and public programs have together successfully addressed a number of social welfare concerns like retirement income security, health care financing and disability protection. The history of social welfare programs in this country as well as the particular interests of the private and public sector, strongly suggest that over time the financing of long-term care services will be addressed with a mixture of public and private financial programs. Social problems are not the primary responsibility of one or the other sector. The correct combination of public/private financing is unclear, but one would hope it would be tied to social goals of adequately providing access to care and ensuring quality of services at the least total cost.

There are two basic views regarding the public roles in the solution to the long-term care financing problem. One view holds that government should take the lead in solving the problem leaving the private sector to fill in small gaps such as is now the case with acute health care for the aged -- Medicare with Medigap policies. An alternative view is that public intervention should be determined by the inability of the private sector to meet social goals. Based on current evidence, it might be premature to suggest that there is market failure in the area of long-term care. The entry of a significant number of private insurers has obviated one condition of market failure, i.e. lack of interest of suppliers. Thus, a financing strategy that incorporates the public and private sectors is appropriate for the 1990's, whereas it was not at the beginning of the last decade.

Recently LifePlans' conducted research on the costs and benefits of alternative public financing strategies and the impact they would have on the private sector. The LifePlans study started from the perspective that the government role should be defined by the deficiencies in the private market. The first issue examined was whether there existed a potential market for private long-term care insurance. The population was divided into two segments. One consisting of those individuals who on the basis of either income or health status would not qualify for private long-term care insurance, and the other consisting of those individuals who could afford to buy a private insurance policy. We believe that over 40 percent of the elderly could, based on income, assets and health status afford to purchase long-term care insurance. Affordability coupled with the fact that the decision to use long-term care services is private and personal, leads me to believe that our view of first determining how much private financing 1could accomplish is preferable. This argument is no doubt strengthened by the limited availability of public dollars. Table 3 depicts LifePlans' estimate on affordability which show that whereas 50 percent of those 65-74 years of age could afford long-term care insurance, only eight percent of those above 85 years of age can.

One of the important findings of the LifePlans study on alternative public financing strategies relates to the beneficiaries of various financing reform measures. The analysis shows that the marginal benefits of additional public dollars spent through social insurance approaches accrue primarily to higher income people -- about one third of additional benefits accrue to people with annual income of more than $30,000. Many of these individuals could afford to purchase private insurance. The distributional findings are presented in Figure 1. Moreover, such social insurance programs -- which provide either front end or back end public dollars -- would annually cost between $15 and $20 billion additionally to implement. These social programs would serve largely to preserve assets for many elderly people and their families. We found that a social insurance program providing home care and front-end nursing home care had slightly less distributional effects. The reason why social insurance programs predominantly benefit wealthier elderly is straight forward: the current Medicaid program is well-targeted on the poorer elderly.

A modest public financing proposal which increased financial eligibility levels for Medicaid nursing home coverage to $12,000 would primarily benefit lower or moderate income elderly and would cost about $3 billion annually. Moreover, an expansion of Medicaid financed home care benefits to poor functionally disabled elderly in the community would cost about $4 billion. This public program expansion would assist a population unable to afford or qualify for private insurance. It would also reduce by half the percentage of private pay nursing home residents who spend-down to Medicaid. The availability of slightly more assets for Medicaid eligible would assist short stay nursing home residents in returning to their homes. Based on the costs of such a reform and the public policy objectives it serves, the Medicaid enhancement proposal warrants serious consideration by policy makers for financing long-term care.

Each of the financing proposals we examined depended in varying degree on one or more of the following sources of additional money: an increase in Social Security tax (FICA) rates and/or an increase on maximum taxable FICA earnings; a proportional increase in personal federal income tax rates; and an increase in federal estate tax rates. The effective tax bases of these financing mechanisms are different. Given the different revenue base for each of these taxes, there are implications for money transfers between generations, between labor and capital, and among individuals of the same generation. Therefore, selecting the type of tax by which long-term care will be financed is critical. Table 4 shows that households headed by people aged 25 to 54 account for more than three-quarters of total labor income but less than one-third of capital income. The elderly account for only 3.5 percent of labor income, but 45 percent of capital income. The analysis indicated that in the near term almost all the benefits from proposed long-term care programs will be received by the elderly who would pay only 3.7 cents of every dollar financed through the FICA tax or would pay only 13.5 cents per dollar if long-term care is financed through income taxes.

Increased funding through Medicaid will largely meet the public responsibility in developing the appropriate public/private financing partnership. But, it will not be enough.

3. <u>The Need For Leadership By Government</u>

Long-term Care:

While there may be difference amongst researchers and policy analysts on the nature of the public/private partnership there is no doubt in my mind that the leadership role must be provided by the government if we are to solve this social problem. The government in the long-term care market, like other markets, must establish the environment, parameters and rules under which the private market should operate. As stated by Justice Brandeis in Olmstead versus the United States: "Our government, is the potent, the omnipresent teacher. For good or ill, it teaches the whole people by example."

I believe the government, in establishing the environment, should perform the following key functions:

(a) Address the problems faced by those who cannot afford to protect themselves against catastrophic long-term care expenses, either because of their health status or because of their incomes and asset levels;

(b) Educate the public on the risk and nature of long-term care costs and the shortcomings that exist in current government programs;

(c) Provide incentives to encourage the working population and older people to protect themselves against catastrophic long-term care expenses. One way of doing this is by qualifying long-term care insurance plans that receive favorable tax treatment; and

(d) Develop a consumer protection strategy that focuses on screening out bad carriers, supports high-value products and offers wide choices for consumers.

Acute Care:

While enhancing Medicaid and providing leadership with regard to private long-term care insurance plans will improve the financing of long-term care, perhaps the most important action the government could take is to improve Medicare and the efficiency of the acute care system.

About 70 percent or so of the elderly have a Medigap policy today and the price of these policies is, on average, approaching long-term care plans. The elderly perceive a real need to have this coverage even though the vast proportion of the premium does not provide financial protection from catastrophic expenses. Paying $75 or $100 a month for a Medigap policy may mean that there is no disposable income left for long-term care insurance.

Long-term care insurance, as stated before, is directed towards protecting individuals against the catastrophic costs they might have to bear. The benefits provided by Medigap policies are first dollars as they fill-in Medicare's co-payments and deductibles. The well known end result of Medigap coverage is over consumption of services, higher Medicare expenditures and inability to establish financial incentives for appropriate service use. Another shortcoming of Medicare is that care outside of the acute care delivery system, even though for acute episodes, may not be covered. This is true of many nursing home and home health visits.

The success of the four Social/HMO sites, which were designed to provide a health care benefit structure appropriate for the elderly under a managed care program with broad community care benefits, illustrates that the provision of short-term nursing and home health care can be done within existing Medicare expenditures. The Social/HMO defines the mission of its community care benefits, not simply as providing community care support and front-end nursing home protection for the disabled, but rather as pulling together the entire skilled, unskilled and extended care support system, including Medicare's home health and SNF benefits. In addition to delivering Medicare SNF and home health care, eligibility for community long-term care benefits is based on meeting state nursing home admission criteria, which differ by site but in all cases are multi-dimensional, including not only ADL limitations, but also some key IADL problems (e.g., medication management, cognitive disability, and nursing/therapy needs). This eligibility structure allows S/HMOs to provide extended acute care services that fill the gaps left by restrictive skilled care definitions, and transitional benefits.

The S/HMO program costs Medicare no additional dollars. The Medicare payment -- 100 percent of the AAPCC -- together with premiums averaging about $55 per month across the four sites cover the costs of providing a comprehensive and extended benefit package that even includes prescription drugs and on going home health care. This is possible because under the S/HMO program substantially fewer hospital days are consumed, about two days per enrollee in the S/HMO as compared to three days per enrollee under Medicare. By having one less hospital day per enrollee cost savings of over $600 per person occur and these savings make it possible to provide a lot of other benefits. In particular the case managed long-term care benefits of the S/HMO costs between $300 and $400 a year. A more restrictive benefit package targeted at the extension of acute care needs and for transitional care will cost less than the S/HMO benefit package.

I believe the success of the S/HMO concept can be tied to managed care and having one integrated financing system. These attributes can occur outside of HMOs. In last years budget reconciliation, Congress legislated four additional S/HMO programs. Hopefully, this demonstration will expand the models to other organized systems as well, incorporating managed fee-for-service and PPOs. I believe, with the proper incentives, private sector insurers and providers can be expected to introduce more efficient treatment patterns. By introducing these changes within the Medicare program on a wide basis an improved Medicare program in terms of access, quality and cost effectiveness could emerge. More for fewer dollars is possible.

Conclusion

An improved Medicare program providing services for those needing extended care, following a recent acute care episode and transitional benefits for those becoming permanently disabled will appropriately round out the Medicare service package. Long-term care benefits not linked to skilled care needs of a short duration, such as 60 days of nursing home care, will be an appropriate complement to private long-term care insurance that should be providing catastrophic benefits. Obviously, such an approach would eliminate prior hospitalization and replace it with an assessment of need. Further, these improvements coupled with better management of the benefits systems, and integration of Medicare and any supplemental financing might release substantial dollars that individuals could use for purchasing long-term care insurance. Clarity in the differences of the benefit structure will go a long way toward distinguishing the long-term care market from the acute care market and educating the public as to the extent of Medicare's coverage for services provided by long-term care providers. While I do not believe that the number of individuals purchasing private long-term care insurance plans will approach the Medigap proportion of 70 percent, it could approach the 40 or so percent who could potentially buy a private long-term care policy. A far cry from today's 4 percent. For individuals who cannot protect themselves because of either inadequate income or poor health, a more humane Medicaid program is the answer. By relying upon an improved Medicaid program and private longterm care insurance, the government would be accomplishing it's role of assuring access to longterm care while not assuring but rather encouraging asset protection.

Finally, the government leadership I have been discussing in developing adequate financing for longterm care and in achieving efficiencies and expansions in acute care need not cost the federal substantial new dollars. More importantly, the success or failure of the private sector in solving these social problems will depend on the nature and scope of government intervention. While the public sector strategies will be much less expensive than full social insurance within an unmanaged system, the program envisioned will require more systemic changes, more policy leadership as well as substantial management skill and ingenuity from the government.

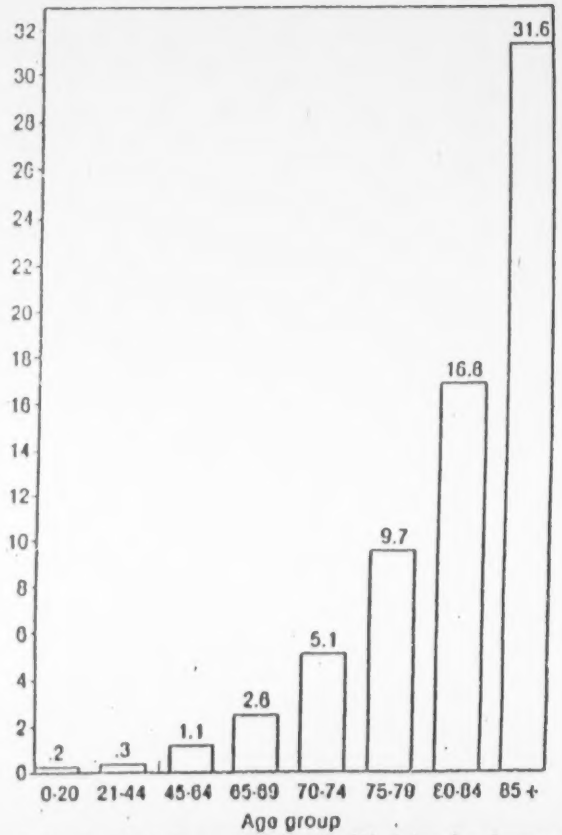
TABLE 1

RISKS AND COSTS OF LONG-TERM CARE FOR PERSONS AGED 65-74 YEARS

Length of Stay in Nursing Home	Portion of Population Staying this Long	Average Lifetime Cost at $80/day
ZERO DAYS	56%	$ 0
UP TO 1 MONTH	13%	$ 1,200
1 TO 3 MONTHS	9%	$ 4,800
3 TO 12 MONTHS	9%	$ 18,000
1 TO 2 YEARS	4%	$ 43,800
2 TO 5 YEARS	5%	$102,200
5 YEARS OR MORE	4%	$204,000

Source: Cohen, Tell, Wallack, The LifePlans Risk and Costs of Nursing Home Care Among the Elderly - Medical Care - December 1986.

TABLE _: EFFECT OF AGE ON NEED FOR LTC



Source: National Nursing Home Survey and the Health Interview Survey and the U.S. Bureau of Census.

TABLE 3

ELIGIBLE ELDERLY MARKET FOR LONG-TERM CARE INSURANCE

PERCENTAGE INELIGIBLE BASED ON

AGE GROUPS	INCOME & ASSETS	DISABLED IN NURSING HOME	DISABLED IN COMMUNITY	TOTAL COMBINED*	TOTAL PERCENTAGE QUALIFYING
65 TO 74	46%	1%	7%	50%	50%
75 TO 84	54	8	10	62	38
85 AND UP	82	21	24	92	8
WEIGHTED TOTAL	52	5	10	58	42

* THE TOTAL PERCENTAGE INELIGIBLE REFLECTS THE OVERLAP OF THOSE NOT QUALIFYING BECAUSE OF INCOME, ASSETS AND HEALTH STATUS

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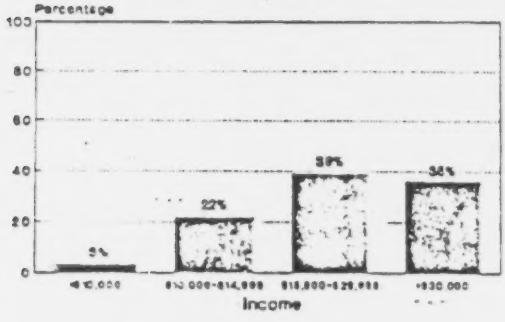
FIGURE 1

Distribution of Additional Public Long-Term Care Dollars by Elderly Income Groups under Two Social Insurance Approaches, 1990

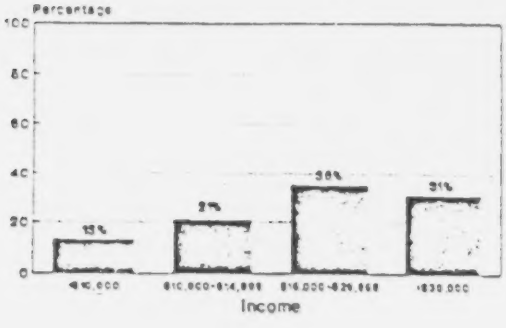
Back-End Program

Additional Public Funding: $15.3 Billion



Front-End Program

Additional Public Funding: $19.7 Billion



Source: Lifespans, Inc., Long-Term Care Model, 1990.

TABLE 4

DISTRIBUTION OF HOUSEHOLD INCOME

AGE GROUP OF HOUSEHOLD HEAD

TYPE OF INCOME	15-24	25-34	35-44	45-54	55-64	65+
TOTAL	.043	.225	.240	.193	.166	.134
LABOR	.048	.267	.277	.216	.155	.037
CAPITAL	.010	.063	.113	.125	.238	.450

SOURCE: CHANGES IN THE AGE DISTRIBUTION OF INCOME IN THE U.S., 1982-84 POSNER,KOTLIKOFF, AND KNETTER(1985) NBER: WORKING PAPER NO 1716

Chairman STARK. Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

I think that there is a lot more we can do here to encourage the purchase of private long-term care insurance by turning loose the private market.

One idea a number of us have talked about would be to permit life insurance companies, in cases where people above the age of 65 have paid up policies in substantial reserves, to provide a long-term care rider. That would reduce the amount of the reserves. It would reduce the amount of available life insurance. It would require no cash from the policy holder.

If we did it right, it would trigger no taxable event. If we had all the life insurance salesmen of America out there, in cases like this, I think 40 percent could go up substantially and permit people to protect their own assets by drawing down on reserves that many of them don't know they have.

It doesn't affect the cash they have to live on or their taxable income. It would have little tax effect because most of their life insurance goes into their estates or to their heirs tax free at their death. There might be very little tax expenditure.

I wonder in that connection, Dr. Rowe, I may have written down what you said incorrectly, but you used the word "downside." I think, the downside of the long-term care insurance if I recall correctly. What did you mean by that, please?

Dr. ROWE. Mr. Gradison, first in response to your comments, I agree with what you say. I think there are many older persons in the United States that have equity, be it in a life insurance policy or even in their home, that could be converted to be used for long-term care insurance in a relatively painless way for them, with out-of-pocket expenditures.

There are two pieces to the problem. The other piece of the problem is that I don't believe 40 percent of the elders have looked into long-term care insurance and decided it is too expensive and stepped back from it. Many, many fewer have looked into it because they are not aware of it. They think they are covered under Medicare or some other reason.

I think we need to not only help them with the cash flow aspects of it, but bring it to their attention more effectively.

What I meant when I referred to the potential adverse effects, I was responding to the issue of should we fund a front end or a back end. And I wanted to fund a back end because the front end, although it will help everyone, is a sure way to spend a lot of money when everyone is going to be in a nursing home for a short period of time.

The expense of $6,000 to $9,000, I don't see as that great. I do recognize that there are impoverished people, and when they get back home, they don't have funds to support themselves. Those people who will be impoverished by $7,000 in expenses are the people who can't afford short-term care insurance unless they have a policy to cover them. Those people would be handled by increasing the threshold for the spend down.

Mr. GRADISON. That is very helpful. I thought there would be more support than I sense that there is from the insurance indus-

try toward a public program that helped in the long term, the back end, whatever it is called.

It would seem to me, just as a layman, that shorter stays would be easier to insure. You won't have the long tails of insurance that are so difficult to project and to pay for.

When we discussed this issue in the Pepper Commission, we spent a lot of time on the front end/rear end issue. At least my recollection is, we didn't get a very clear signal from the industry as far as what their recommendations were on this; the commission brilliantly compromising the issue by saying they would do both, which of course begged the question.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Moody.

Mr. MOODY. Thank you.

Dr. Wallack, can you walk through with me, again, the demographics? You are saying 40 percent of the people could afford long-term health care in a private market? It is an insurable event, statistically?

Mr. WALLACK. This question of affordability is not an easy one. Many people say they have limited income and what could they afford? I think the issue, it is really an issue of looking at their assets, their income, and saying can they afford the current prevailing policies that are selling out there?

It is partly, it is a judgment call to some extent. We look at assets and income and said we thought roughly 40 percent could afford it. To say—and that is a rough cut. Clearly it is not 5 percent and 10 percent and it isn't 70 percent. It is 30 to 50 percent. That has a sense of reasonableness about it because 70 percent or so of the population have a medigap policy which doesn't cost that much different than a lot of long-term care policies.

As we know, medigap policies are providing first dollar, front-end protection and people are willing to pay for it. They feel they need that. There isn't the same mind set with regard to long-term care. Maybe they don't appreciate the risk. Maybe they need to be educated more about it. Maybe they are very confused because of medicare and not knowing what covers it.

There clearly is a lot that needs to happen out there to educate that marketplace and give it some incentive for purchasing.

Mr. MOODY. Since it is an insurable risk with predictable behavior, why haven't private companies moved in to explain that Medicare won't cover this? That you will be uncovered at some point, or at least you have a chance of being uncovered, and we have a premium which you can afford.

Mr. WALLACK. I think they are trying very hard. What we didn't have a few years ago is, are companies out there that want to sincerely commit themselves to this industry. You now have what I consider to be A-plus companies that want to sell in this marketplace.

They are finding it is a very long sale. You have to spend a lot of time there, educate the people about the problem. There is an awful lot of question. It takes many hours. We are in the beginning of a new era and a new product. It is also really key that the Federal Government, I think, create some credibility for this if they want it to happen.

Again, the elderly, because of Social Security, because of Medicare, they look to the government. They look to somebody who makes it credible to them. They look to the government when they are older or they look to their employer if they are younger.

People will buy long-term care insurance more likely if their employer recommends it. It is the same way older retired people look to their government. They need credibility out there. There isn't very much.

Plus, as you know, you hear about these horror stories. There are a number of companies out there that are not providing very solid policies and good benefits. They are providing illusionary benefits. The industry needs to be regulating. There needs to be confidence in that marketplace.

Dr. ROWE. Mr. Moody, I think it is important to realize that in long-term care insurance, what we are doing is, not paying premiums for services that are going to be rendered that year. Like in health care insurance, you pay your annual premium to Blue Cross.

If you need hospitalization, it is covered. In long-term care insurance we are paying for something that might happen in 20 years, very difficult for people to understand.

Mr. MOODY. It is like long-term fire insurance.

Dr. ROWE. Right. Insurance companies have not been able to gauge the risk. They don't know where to put the premiums. They put them high. They are scared by studies that show that 50 percent of old people have Alzheimer's disease. They are concerned American medicine with technology is prolonging dying rather than living independently. There are lots of unknown——

Mr. MOODY. Every technological breakthrough fattens the tail on distribution.

Dr. ROWE. There are lots of unknowns which have hindered the development of crisp policies.

Mr. WALLACK. Let me add one thing because I work a lot with companies in terms of pricing their programs and looking at their actuarial risk. It turns out the experience with a lot of prior policies is actually better than the experience if you look at nursing home use and length of stay.

That is because the public data is driven by Medicaid experience. In fact, I think people are surprised sometimes by those private rates out there. They think that somebody is tricking the individual. In fact, the experience is pretty favorable. If anything, the rates are coming down because people don't want to enter a nursing home.

Mr. MOODY. People don't really want to get into nursing homes, usually.

Are there some Government impediments for selling long-term care in the private market?

Dr. ROWE. I think if the Government gets out of the way, the risk in some people's mind is that insurance companies will insure those people with the lowest risks, not insure those people with moderate or high risk, leaving those people uncovered. That sort of skimming is something that would have to be assiduously avoided.

Mr. MOODY. Are there any other Government impediments you know of for the private market of long-term care?

Mr. WALLACK. Now.

Mr. MOODY. It seems you are saying the Government should step forward and provide some frame work.

Mr. WALLACK. There is discussion in various committees about establishing standards. I think there needs to be some kind of discussion about consumer protection.

I think the real issue is, what do you want to see out there happen, a social program or a private program? The Government needs to set the environment and the rules. The government, State or Federal, needs to do it in this industry and needs to give encouragement to people.

Mr. LEVIN. When one hears the data you provide, it is not really new, but it is rather striking, the amount that is spent on the shorter term stays in nursing homes, the percentage of those who can afford long-term care and would get the benefits from a comprehensive program. It strikes me like it is a call to revive catastrophic health coverage.

Why do you think, in view of the facts that you give, it reached such a quick demise?

Mr. WALLACK. My own feeling? Are you asking me or Dr. Rowe?

Mr. LEVIN. Either one.

Mr. WALLACK. I think one of the problems we have, and I am certainly as guilty having spent a number of years in Washington and CBO, is sometimes we have to understand what a public policy is going to do on the private sector and the difference between the two.

I think some people thought that there would be reductions in medigap, we would cover more of those benefits and the price of those policies would go down.

They didn't go down. If anything, they started to go up. People, I think, said what is going on. We have got a catastrophic benefit and my medigap policy isn't going down. This caused a great deal of confusion. What was going on?

I think the other issue, of course, is who pays. If you develop a long-term care program, and let's assume the elderly were well educated and decided not to buy it. If you developed a long-term care policy for asset protection, and asked them to pay for it, that may lead to another catastrophic debacle because they would say we don't want it.

Mr. LEVIN. Wait a minute, though. How, in view of your data about who can afford it and where the benefits would go, there is going to be asset protection in any long-term care program except Medicaid.

I mean, I think your data indicate that you are going to have to somewhat tailor a long-term care program to income or assets or something. Your critique of a comprehensive program is 70 percent of the benefits would go to those who could afford long-term care. That is an attack on those who want a comprehensive so-called program. Keep going, though.

Mr. WALLACK. I am not sure it is as much an attack as to take into account who benefits and who should be paying is what I was trying to get at.

I think your are raising the fundamental question. When you cut all through it, you are actually on the right question. It isn't a

social insurance program versus a private insurance program. It is, do we want a private program or do we want a Government program? That is the question we should be debating.

I think there are a number of people who believe the Government can do a better job. The essence really is, do we want to develop something which is really a private market solution program?

What I am arguing is the following: I think we could improve Medicaid and really assure access. I think we can take care of quality through proper consumer protection. I think we would do risk protection through the private market.

The issue is, do you think it would be better to have the government run a social program or do you think it would be better to have a lot of varieties of private sector products and various choices out there?

I come out in one coherent conversation talking about an expanded Medicare program, catastrophic benefits, more integrated program. But when I come to long-term care, I am looking at what I believe is very personal, we are looking at tremendous after-protection. There is a difference in social objectives.

Some people won't think at all, ever, of going into a nursing home. Families won't think of it. Somebody else might prefer a home. It is a private thing.

Given the nature of the good, and given that I think you could do it through private insurance, I would say let's try to go as far as we can with the private market. We have got limited dollars. Then look for the appropriate role for the public sector.

The essence of what I am getting at is, do you want a social program or do you want to develop a private program with private financing behind it? I think that really is the question.

Dr. ROWE. I would vote for the social program and feel that you had to phase it in, and the gap in the beginning, before it could be fully funded, should be covered by private insurance. My philosophy, just to provide a counterpoint to my distinguished colleague, would be that long-term care is really a right, not a privilege. We have to assure that it is available to everyone, and a social program would do that.

Chairman STARK. Thank you.

Mr. MOODY. Would the gentleman yield one second?

Mr. LEVIN. I saw the light turning to red. Sure.

Mr. MOODY. He asked you about why you thought catastrophic bit the dust. Is it possible that part of the reason was that Congress, because of deficit pressures, prefunded it? We asked people to start paying before the benefits kicked in?

People, heard about this new bill and some of them couldn't really cancel their medigap.

Because of the deficit, we front-loaded the program. In fact, there was a lot of money front-loaded on that process to help provide deficit reduction. That might have been part of it. Do you have any comment?

Dr. ROWE. Older persons didn't understand it. Just like they think they are covered for long-term care under Medicare, and we didn't educate them.

You spent a lot of time in this room and in this building crafting something that we felt they needed, but we didn't educate them, and they didn't understand it. They saw the price tag, and it was too high.

Chairman STARK. This is one of the problems with having brilliant authors of legislation. It gets so far above the average intellect in this country.

Mr. LEVIN. The chairman speaks for himself.

Mr. GRADISON. We suffered through this. It started and ended in defeat as the Stark-Gradison bill. I appreciate a lot of the objections that were raised—that people were paying for benefits they were already getting, something like 6 million it turned out.

I also think, with hindsight, that making it mandatory was a big mistake. I know about adverse selection. If you look somebody in the eye and say, if you don't sign up, you got one chance. If you don't sign up, you pay your own long-term care. You would probably get a lot of people to come in. At least they made that decision themselves.

Dr. ROWE. They basically didn't trust us.

Chairman STARK. Mr. McGrath.

Mr. MCGRATH. Thank you, Mr. Chairman.

Thank you, Jack and Stan, for your testimony.

I will only parrot and confirm what the last comment was regarding the catastrophic bill. My mother lived just on Social Security. You wouldn't believe her own son voted for it, that this was a good deal for her.

Let me ask you, Stan, you have made reference to the fact that we need to improve Medicare to delineate the roles of what—for the public and private sector—what the long-term care should be about.

Let me ask you, what do you think? Other than going back to the catastrophic benefits, what kind of benefits are you looking at in terms of improving Medicare so that we have a better idea what the medical—perhaps there is a medical role of what long-term care should be about.

Mr. WALLACK. I was really trying to talk about improvement in three dimensions. The first dimension was around benefits. And there I think you could take—I agree with Dr. Rowe—you could take the focus of some nursing home care, some health care, don't apply restrictions based on skill level.

A number of these individuals are medically unstable but some short stayers do not meet Medicare rules. I think we can do a lot if we develop a more rational program at the broad policy set level of financing it and organizing it.

One of the real major problems here is we basically have medicare and medigap filling in and the result of that is again two financing streams, not letting policy really take force. I think it was true in the catastrophic bill. If we can find a way of putting those two financing streams together, I think that is terribly important in developing a rational system.

I know we can manage the care of this population and reduce the hospital costs quite a bit. Doing those things, by changing the financing, by thinking about how to manage the system a little

more and by providing the needed benefits not having it cost any more is attainable. I think you can do a lot more with less dollars.

Mr. MCGRATH. We used to say in New York, I was there some moons ago, that 25 percent of the acute care beds were being used by long-term nursing care-type patients.

Jack, does that still exist to that extent or has it gotten worse?

Dr. ROWE. Yes, it does, Mr. McGrath. What we have in the United States is the dislocation of the kind of care and the place it is given. We are providing long-term care to people in acute care facilities, largely because there is no place for them to go. Particularly in New York, where there hasn't been much building in the long-term care sector for several years.

One of the pressures is, there is no place to send a patient. So there is a dislocation and we are giving a lot of long-term care to people in acute care hospitals. That is risky.

I am very sorry to have to share with you the news that to have older people who do not need acute care in acute care environments poses financial as well as clinical risk. We need a way to keep people out of the hospital, not keep them in it. Certainly getting rid of the 3-day required hospitalization, is a start in terms of what clinical sense it makes.

Mr. MCGRATH. You seem to, both of you, have a difference of opinion as to the eventual outcome of how a long-term system should be structured. One, as we do in the national health insurance program, one side seems to feel that there ought to be a single paying government social contract, versus the other side being a combination public/private.

I am wondering whether or not my view of our opinions is correct and why your opinion is in that direction.

Dr. ROWE. I suspect you are correct, Mr. McGrath. I suspect we may have been chosen for that difference of opinion, and it is the pluralism that makes America great. I think these are basically different philosophical views.

I suspect that if Professor Wallack and I were asked to talk about the functional aspect of what and who would be covered, we would be talking about the same thing. We want to get to the same place. We are just talking about different methods of getting there.

And my basic thrust is in a more social system where I think there would not be adverse selection, and that those people who couldn't afford it would be given as fine a product as those who could.

Mr. WALLACK. I think we talked about a single payer. I would like to differentiate sort of the single financing instrument from—when I talk about merging the streams of payment, what I am really thinking about there is at the provider level, it could come from a medigap policy, it could come from the government, but actually the streams of financing are consistent. They don't conflict with one another. It could be a management on fee for service bases going through an insurance company, or it could be a PPO or HMO.

The merging of the financing system at the provider level is the key to getting the kind of flexibility that you want. They could take the dollars and put them in the right place to effect an effec-

tive delivery system. A lot of what we talked about is sort of who bears the burden in these income distribution issues.

I use the word financing in a slightly different way, let's take those pools of dollars and make them work together.

Dr. ROWE. I would like to add if I can, the General Accounting Office has put together some data I have seen as a member of their health advisory committee which clearly indicate, looking at international comparisons, that you can control costs and provide benefits either with a multiple payer system or a single payer system. Either of these can work.

Mr. MCGRATH. I tend to agree. Sometimes the comparisons that you see between people who advocate one kind of system versus the other don't—if you take a look at the single payer system versus "the Medicare system," that supposedly is that much more efficient than the private insurance sector on the other side, sometimes it doesn't take into effect all of the expenses on the government side as opposed to what is required for the private sector to take into account on the private sector side. So I agree.

And I thank the Chairman for his indulgence.

Chairman STARK. I want to thank both of the witnesses. We have struggled on the base committee and on the Pepper Commission with the same problems that both of you work on all the time. I am fairly convinced that my distinguished Ranking Member and I were in a distinct minority on the Pepper Commission, in a vote to decide, whether we should focus our benefits to the first few months, or the long term, the 10 or 15 percent that will be there a long time.

We felt, and I still feel, if there is going to be Federal involvement, it ought to be on the catastrophic end, on that end which probably has long-term liabilities which insurance companies like least. The front end or short term is easy to define. People can understand they have savings, it is easier for the insurance companies if they don't want to save for it. I think that is what seniors tend to fear most; long-term incarceration or internment.

Would both of you agree that this is the area, if we have to concentrate on one part of this, and they both are expensive, we ought to leave the short-term financing to individual savings or private insurance, or obviously social for the very poor end, but we should concentrate on the very long term?

Dr. ROWE. From my point of view, Mr. Stark, while I recognize that you and Mr. Gradison feel strongly about this, I believe the Pepper Commission devoted a lot of time to it and vote 11 to 4 in favor of this sort of mixed front and back end.

I support the back end and I support it based on the data from the Brookings Institution and the data from Manton and his colleagues showing that a small proportion of individuals are impoverished during the first few months, and if you give that coverage to everyone, you are going to cover a lot of people who don't need it.

I think there is a rational note only from the point of view of what Americans are concerned about, long-term dementia patients versus the acute stay medically acute patients, but also because the data indicate that a relatively small proportion of individuals become impoverished during a short stay.

So there is a data base rationale in addition to a public feeling rationale.

Mr. WALLACK. I think the tail end is really the catastrophic end of it. Again, people have Medicaid now, and 35 percent are on medicaid when they enter a nursing home, another 13 percent spend down rather quickly, therefore they get public support. The back end is who you are going to be protecting and that is what private insurance is all about.

We should try to encourage people in a society like ours to protect their assets. It is the front end where I see as the real problem. Because the fragmented systems, the 3-month benefit that you talked about in the Pepper Commission, it made perfect sense to me to put it onto Medicare in some way. But really the short term people, who are medically unstable, who have both disability and an acute care problem, it makes sense to put it there. It is an appropriate rounding out of the Medicare package.

Therefore, when I looked at the Pepper Commission, I said, boy, that made a lot of sense, but I would put it on Medicare and really improve the Medicare program and define that as the government program and then look to the private sector to say, you, with all those assets, you should be protecting—we are going to take care of those who can't take care of themselves.

Chairman STARK. The Pepper Commission decided to protect $30,000 for individuals and $60,000 for couples.

There aren't that many people in this country with assets to protect. They may have a little pension or a loan, but it isn't 20 or 30 percent who have enough to keep them a year, and so we are talking about pretty well-to-do people anyway.

Mr. WALLACK. There clearly are relatively small percentages of people who have enough as to the pay for themselves out of their own pocket. The whole issue—it comes into this issue of prefunding.

Chairman STARK. Let me put on my insurance salesman's hat for a minute. I can't figure out whether I think it is insurance or just another annuity product. If you charge them enough, to have enough money, the insurance commissioners are going to get on to you pretty soon because they are not going to let you keep all that cash for the people who don't use it. Then you are back in the box of selling another cash value product that has a different trigger. The industry has done a good job of scaring people to protect the widow or orphan at an average cost of $6,000 to $8,000 for a life insurance policy. They do very well at burial insurance and with very rich people through a lot of estate planning basically because of tax features, but they have never done very well with the middle-class person who could afford it.

So my theory is, if insurance companies are not going to scare you into it to protect your kids and your wife, how are they going to scare you into it to protect yourself when at the age of 20 or 30, you think you are immortal and at the age of 40, invincible and so on? Maybe they should, but they aren't.

Unless you see something in this long-term care product, I don't see how you are going to sell it.

Mr. WALLACK. I am certainly an observer, watching the cycle. I think it is a very different sale when somebody, you know, some-

body keeps on asking me if you bought it and I keep saying no, even though I am supporting private protection. One buys this when one has a real probability of needing it.

When you start to see people get in the late 60s and 70s people start to see over the next 4 or 5 or 10 years, then in fact it makes some sense to buy insurance. When they wait until they really need it, which is 80, there is no way they can afford it. That is the nature of insurance.

The probability is small but real of having this very large catastrophic expenditure, that makes sense for the market. That is who buys these policies, 70-year-olds. We should start to educate these people, because that is when they can see this is real. If you go back and say it is 40-year-olds, building up assets, but it does become more like insurance if you get up to the late 60s and 70s when people start to see some risk.

Chairman STARK. I can't help but think that private insurance will do the job, or as efficiently. Social Security reaches its highest level at about $1,000 a month. So, if somebody received $2,000 a month, maybe a little more, they could be cared for minimally in some kind of nursing or home care facility. But to get that kind of benefit, we would have to double the highest Social Security benefit. Then we would have to increase the payroll tax, and only those who need it get the higher benefit. Do you means test it? Tax it? So you and I have to sit down and decide what is an efficient way to deliver this care which the Government in the end pays for. It's not an easy answer, but Medicaid does not do it.

How would you like to be old in Mississippi and where you don't get Medicaid under any circumstances. I was just in Connecticut with the committee. Connecticut is talking about providing insurance on increasing Medicaid benefits, but they are not facing the reality of how they would pay their share.

Dr. ROWE. Connecticut is near a large state where the health care system is in extremis.

Mr. WALLACK. I think there is a lot of validity in what you are saying, but if you look at the states that are having tremendous financial problems in Medicaid, New York, Connecticut, Massachusetts and California, those states I am familiar, they basically have an insurance program for long-term care. A very large percentage of people are on Medicaid. They pay the highest nursing home rates.

There is a real issue about how we are sharing that burden because they do and they have gotten themselves in an unbelievable financial pressure.

The question that comes back is the financing. Do we have—the Federal Government has limited resources. I work in long-term care and acute care, also in the drug abuse area. In dealing with poor people and drug problems, the question is, where are we going to put our bucks? As I look at it, I would say, if I had my choice, would I rather give it to poor people or give it to asset protection for middle-income, aged people. I know where I would come out.

Mr. MCGRATH. The State of New York has a $6 billion deficit this year and looks like it has a similar kind of constitutional deficit over the next few years, for a lot of reasons, but among those being lack of a revenue stream at this point.

The hospital reimbursements are being taxed on Medicaid about six-tenths of 1 percent because they don't get the Federal Government cuts. That is going to increase to 1 percent this year.

Medicaid in my county, Medicaid being a 50–50 deal, but in New York 25 percent or a quarter of the cost comes from the local social service district. That expenditure in New York for Nassau County represents the second highest expenditure. So when I tell you that every major county executive and the governor in our state are looking to cut Medicaid, the trend is not towards increasing medicaid benefits anywhere, particularly in the states which you have outlined, and particularly in the northeast.

I would suggest that Medicaid may not be the place to start looking in terms of providing these expanded benefits.

Mr. WALLACK. All I was really saying is we have already created in some States a social insurance program for Medicaid and it is a very expensive program and I think it is a mind set. I have never seen the survey of people in New York State, but if something like 80, 90 percent of the people in New York State are on Medicaid, you may have the figure, but that is much higher than the national average.

You have got a system where the states basically pay very reasonable rates. The providers don't mind taking Medicaid. In fact, medicaid is a very generous program. Individuals know they got good service. It isn't like the people in New York are poor. It is a mixed population, but it is not necessarily a poor State. The high proportion of people on Medicaid——

It is a result of divestiture.

I guess it would be an interesting study to look at. People in New York expect to be taken care of and they in fact divest their assets and go on Medicaid. So we have effectively created the social insurance mind set. It is very hard to go back.

Mr. LEVIN. Mr. Pickle has joined us, our beloved colleague.

Any questions, Mr. Pickle.

Mr. PICKLE. No.

Mr. LEVIN. This has been very, very stimulating indeed, as you can tell by the length of the questions, and we have delayed our next panelists, so we will say au revoir, see you again. Thank you very much.

Our next witness is Jeffrey Sanders, Director of the Office of Legislation and Policy, Health Care Financing Administration.

We will have the prepared statement entered in the record. Go to the heart of your testimony, if you would like, or however you want to proceed.

STATEMENT OF JEFFREY G. SANDERS, DIRECTOR, OFFICE OF LEGISLATION AND POLICY, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. SANDERS. I am pleased to be here today representing the Department of Health and Human Services.

The administration is well aware of the difficulty many older people now face in finding ways to finance their long-term care needs. We are aware that over the next 20 to 30 years, the demand

for long-term care services could be more than double as the baby boomers reach old age. That increased future need is a double-edged sword. It highlights the need for addressing these issues and it also highlights the need for developing a sustainable system.

Over time, the economy isn't going to grow nearly as quickly as the demand for long-term care services. So it is important, as society debates this issue, that we set up a system that not only works today but works 20 to 30 years from today when there will be a lot more people relative to the population who need long-term care services.

The question that faces us as a society is how to apportion responsibility for paying for and providing long-term care among elderly persons and their families, the public sector, and private financing arrangements like long-term care insurance.

The financial pressures of existing health benefits force us to carefully consider any increase in expenditures for Federal program expansions. We must consider what care should be provided under the Medicare program or the social insurance model, who should qualify for any new benefits, and the criteria for coverage. Who will pay for the increased benefits, of course, is a paramount concern.

From its inception in 1965, the primary purpose of the Medicare program has been to provide older Americans with protection from the high cost of acute medical illness.

In determining what Medicare will and will not pay for, a boundary has been drawn between services oriented toward the treatment of acute illness and those primarily custodial in nature. I think that is part of the criticism of current Medicare benefits. Many of them result because people look at Medicare from a long-term care perspective when in fact it was established as an acute care benefit.

Changing this boundary has serious and far-reaching implications. Expansions should be considered as part of the broader debate about long-term care policy directions. Piecemeal changes may turn out to be costly, misleading, and ultimately counterproductive.

In 1990, Medicare spent about $3.5 billion for skilled nursing facility care and about $3.2 billion for home health care. Since 1985, spending on the Medicare benefit for skilled nursing facilities has increased over 500 percent, while spending on the home health benefit has increased 50 percent.

Patients can receive skilled nursing facility and home health services only if they required skilled care. After they qualify, the benefit is limited by the amount or frequency of services that are covered.

In 1988, HCFA improved its instructions to fiscal intermediaries. The changes made it easier to determine whether beneficiaries met the qualifying level of care to be covered by the Medicare SNF benefit.

In addition, in response to the Duggan case in 1988 involving home health care, we modified our regulations to reflect the new interpretation of part-time or intermittent care by nurses or home health aides.

The Duggan changes also resulted in expanded access to care for chronically ill, homebound beneficiaries. In addition, the settlement provided home health aide services for up to 7 days a week for eligible beneficiaries who need them.

H.R. 1200 would extend daily care provided by home health agencies to 38 days. This would have a modest effect on medicare beneficiaries. Currently, beneficiaries can receive 21 continuous days of care and longer if it can be justified. We estimate only modest costs from such an expansion.

H.R. 1200 would also redefine intermittent to less than 7 days of home care each week. HCFA estimates the cost of redefining intermittent at several hundred million dollars or more per year.

H.R. 1200 would eliminate the SNF requirement for a 3-day prior hospitalization. This would allow more beneficiaries to qualify for SNF care. This is the fairly contentious or complicated change. In the deliberations on catastrophic benefits, we found that everyone had significantly under-estimated the cost of the SNF benefit expansions in that legislation.

Though the benefit was temporarily in place, we did not get enough experience to really understand exactly what led to dramatically unforeseen costs. We believe that the elimination of the 3-day prior hospitalization could cost a billion dollars or more per year.

In summary, the enhanced Medicare benefits of H.R. 1200 are incremental expansions of the benefits initially intended to provide only post-acute services. A very preliminary cost estimate of H.R. 1200 indicates increased expenditures of at least $1.2 billion in fiscal year 1992, mostly due to the elimination of the SNF prior hospital stay.

These costs are an important consideration in estimating the consequence of additional benefits to the Medicare hospital insurance trust fund. The trust fund is already insufficiently financed and under current law will be depleted shortly after the turn of the century.

The administration has serious concerns with moving medicare still further into the long-term care arena. Medicare Part A is already seriously underfunded in the mid-term. Providing long-term care benefits through a social insurance system is both costly and doesn't target benefits to those most in need.

As you know, several groups are currently looking at the larger question of access to health care. The Pepper Commission has already issued its report of findings and the Social Security Advisory Council is expected to come forth with its recommendations later this summer. The National Governors' Association has designated health care reform as its No. 1 priority for this year and is conducting a study that is expected to be complete by August 1991.

A special HHS task force is also charged with exploring solutions to the problems of access and equity. HCFA administrator Gail Wilensky serves as vice chair. The mission of the task force includes a thorough analysis of long-term care issues and options for financing.

Specifically, we are looking for ways to increase the participation of the insurance industry in long-term care. We also want to study carefully the results of other major groups studying this issue.

The benefits that H.R. 1200 would provide may or may not coincide with the findings of the other groups and those of the HHS task force.

In conclusion, the administration cannot support such expansions particularly when they are not financed and would further jeopardize the solvency of the Medicare hospital insurance trust fund. It is essential to think carefully about the costs and benefits of increasing expenditures for skilled nursing and home health care before deciding to push forward with program expansions.

We must first look at our overall goals for long-term care reform. The viability of any proposal to enhance long-term care benefits will depend on the extent to which it falls within the realm of our comprehensive efforts.

We at HHS are eager to work with you as we develop a more thorough strategy for coverage and financing of long-term care in the future.

I would be pleased to answer any questions you may have.

[The prepared statement follows:]

STATEMENT OF JEFFREY G. SANDERS, DIRECTOR, OFFICE OF LEGISLATION AND POLICY, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here representing the Department of Health and Human Services to discuss Medicare skilled nursing facility and home health care. I bring Dr. Wilensky's greetings and regards.

This Administration is well aware of the difficulty many older people now face in finding ways to finance their long-term care needs. We are aware that over the next 20 to 30 years, the demand for long term care services could more than double as the baby boomers reach old age. The question that faces us as a society is how to apportion responsibility for paying for and providing long term care among elderly persons and their families, the public sector and private financing arrangements like long term care insurance.

Financial pressures of existing health benefits force us to carefully consider any increase in expenditures for program expansions. We must consider what care should be provided under the Medicare program, who should qualify for any new benefits, and the criteria for coverage. Who will pay for increased benefits is, of course, a paramount concern.

Medicare's Home Health and Skilled Nursing Facility Benefits

From its inception in 1965, the primary purpose of the Medicare program has been to provide older people with protection from the high costs of acute medical illness. In determining what Medicare will and will not pay for, a boundary has been drawn between services that are oriented toward the treatment of acute illness and services that are primarily custodial in nature. Changing this boundary has serious and far reaching implications. Expansions which move Medicare into long-term care should be considered as part of a broader debate about long-term care policy directions. Piecemeal changes may turn out to be costly, misleading and ultimately counter productive.

In 1990, Medicare spent $3.5 billion for skilled nursing facility (SNF) care and $3.2 billion for home health care. Together this represents 6 percent of all Medicare spending and an increase of over 500 percent and 47 percent respectively, above spending in 1985.

Patients can receive SNF and home health services only if they require skilled care. After they qualify, the benefit is limited by amount or frequency of services that are covered.

In 1988, HCFA clarified Medicare coverage guidelines and improved our instructions to fiscal intermediaries. The changes made it easier for the intermediaries to determine whether beneficiaries met the qualifying level of care to be covered by the Medicare SNF benefit. We also trained intermediaries to provide a more accurate and consistent application of Medicare requirements. This has resulted in improved program administration and an overall increase in the amount of SNF care provided to beneficiaries.

In response to the Duggan case in 1988 involving home health care, we modified our regulations to reflect the new interpretation of "part time or intermittent" care by nurses or home health aides. The Duggan changes also resulted in expanded access to care for chronically ill, homebound beneficiaries. In particular, the settlement provided home health aide services to be provided for up to 7 days a week for eligible beneficiaries who need them.

The current coinsurance for the SNF benefit is $78.50 per day and takes effect after the 20th day. This coinsurance is often more than the daily cost of care. In stark contrast, there is currently no coinsurance under the home health benefit.

Proposal to Expand Medicare Coverage
H.R. 1200 would:

- extend "daily care" provided by home health agencies to 38 days and would have a modest effect on Medicare beneficiaries. Currently, beneficiaries can receive 21 continuous days of care and longer if it can be justified. We estimate modest costs from such an expansion.
- redefine "intermittent" to less than 7 days of home care each week. HCFA estimates the cost of redefining "intermittent" at several hundred million dollars or more per year.

- eliminate the three day prior stay requirement for SNF care, allowing some beneficiaries who would otherwise be ineligible, to qualify for skilled nursing care. Due to a number of factors, it is extremely difficult to estimate exactly how many elderly would actually benefit and what it would cost.

We found that everyone had significantly underestimated the costs of the SNF benefit expansions when the catastrophic legislation was temporarily in place. However, our experience with the catastrophic benefit was too limited to provide us with an adequate basis for understanding what led to the unforeseen costs.

We are concerned that a better understanding is needed before we re-address the SNF expansions included in the catastrophic legislation. We are working with outside groups in developing such an understanding.

H.R. 1200 does not address the existing cost-sharing structure for the SNF and home health benefits.
Additionally, the enhanced Medicare benefits do little to address the issue of long term care for our nation's seniors. They are incremental expansions of Medicare benefits initially intended to provide only post-acute services.

A very preliminary cost estimate of H.R. 1200 indicates increased expenditures of at least $1.2 billion in FY 1992, mostly due to the elimination of the SNF prior hospital stay. These costs are an important consideration in estimating the consequence of additional benefits to the Medicare Hospital Insurance Trust Fund. The Trust Fund is already insufficiently financed and, under current law, will be depleted shortly after the turn of the century.

For fiscal year 1992, without any legislative changes, Medicare program expenditures are expected to increase more than 13 percent. Until we find a way to contain the escalation of Medicare and other health care costs, we should not expand benefits.

We have serious concerns with moving Medicare still further into the long-term care arena. Medicare Part A is already seriously underfunded in the mid-term. Providing long-term care benefits through a social insurance system is both costly and doesn't target benefits to those most in need.

It also would be particularly troubling if, like the experience under Medicare Catastrophic Coverage Act, many of the nation's elderly mistakenly believed such modest expansions as these were actually going to provide them with long-term care coverage.

As you know, several groups are currently looking at the larger question of access to health care. The U.S. Bipartisan Commission on Comprehensive Health Care -- the Pepper Commission -- has already issued its report of findings, and the Social Security Advisory Council is also expected to come forth with its

recommendations. The National Governors Association has designated health care reform as its number one priority for this year and is conducting a study that is expected to be complete by August 1991.

A special Departmental Task Force is also charged with exploring solutions to problems of access and equity, of which, the HCFA Administrator Gail Wilensky serves as Vice-Chair. The mission of the Task Force includes a thorough analysis of long term care issues and options for financing initiatives. Specifically, we are looking at ways to increase the participation of the insurance industry in long term care. We also want to study carefully results of the other major groups. The benefits that H.R. 1200 would provide may not coincide with their findings.

These Medicare benefit additions are premature given ongoing efforts to find a comprehensive solution to the problem of access to and coverage of long term care.

Conclusion

In summary, we cannot support such expansions, particularly when they are not financed and would further jeopardize the solvency of the Medicare Hospital Insurance Trust funds.

It is essential to think carefully about the costs and benefits of increasing expenditures for skilled nursing and home health care before deciding to push forward with program expansions. We must first look at our overall goals for long term care reform.

The viability of any proposal to enhance long term care benefits will depend on the extent to which it falls within the realm of our comprehensive efforts. It would be unwise to take a fragmented approach to long term care reform. We at HHS are eager to work with you as we develop a more thorough strategy for coverage and financing of long term care in the future.

I would be pleased to answer any questions you may have.

Mr. LEVIN. Thank you.

I know you are not in a position to give us final answers, but let me just ask you, maybe you will surprise me, but when I read just two sentences from your report, the trust funds, the earlier one about piecemeal changes may turn out to be costly, misleading, ultimately counterproductive, and then on page 5, the trust funds are already insufficiently financed and under current law will be depleted shortly after the turn of the century, it seems to me essentially you are saying, I know there are studies going on, that we should expect the status quo for the next 5 years.

Give me some clue, look ahead 5 years, if you are opposed to anything that is piecemeal and the trust fund is already under pressure, just give me a clue as to what changes could occur that would be any significant step from the status quo.

Mr. SANDERS. I think perhaps those two statements taken together are a little more negative than I choose to be right nov That describes the situation in relation to the Medicare program and the specific bill that was introduced and was the partial topic of this hearing. Medicare itself has some financing problems over the long run and I think the point is that we should be very careful about adding benefits to a Medicare program that in the midterm may not be able to finance those benefits promised to the elderly.

In addition——

Mr. LEVIN. Can you see, look down the road a few years. What do you see that could occur that would be any significant change where you think there would be support coming from HCFA?

Mr. SANDERS. Again, that is a difficult question. There is an active task force under way studying that very issue. We are working on it. At the same time we are waiting for the recommendations of the Steelman Commission. We have the input from the Pepper Commission. We are looking at that. We are looking at the mediplan bill, the broader, long-term care bill.

In terms of specifics, I am not sure I can tell you what we are thinking about at this point. There are options with regard to medicaid. There are fundamental changes we could make to encourage private, long-term care insurance. And always on the platter are the broader social insurance expansions.

Mr. LEVIN. What major changes that would encourage private programs?

Mr. SANDERS. One was mentioned earlier about allowing insurance to be converted to long-term care insurance. Others are——

Mr. LEVIN. Do you know the cost of that?

Mr. SANDERS. No, I do not. I think their general description of it is that the cost should not be that great as long as that is all you are permitting, because of the asset production. There probably would be some cost. I will be happy to get you an estimate of that for the record, though.

[The information follows:]

One option to encourage private pay of long-term care services is to allow individuals to convert or cash-in life insurance policies to pay for long-term care services. This option could potentially save Medicaid dollars. The Health Care Financing Administration actuaries have not done cost estimates at this time.

Mr. SANDERS. There are other options beyond that. For instance, active encouragement of the purchase of long-term care in-

surance. That is usually done through the tax system. The Treasury Department is better able to talk about the specific details. That, of course, is talking about more money, when you are actively encouraging, through tax incentives, the purchase of long-term health insurance. There will be bills pending in Congress that would deal with that as well.

I don't think we have settled on our general direction yet. In that regard, we are like a lot of other people. It is a very difficult, thorny issue.

Chairman STARK. The Chair would like to welcome Mr. Pickle to the subcommittee and see if he would like to ask some questions.

Mr. PICKLE. Thank you, Mr. Chairman. I thank you for the privilege.

I would like to address a couple of questions to the witnesses. You comment on H.R. 1200, and you find it falling short in several instances, particularly with respect to financing. And you say you have certain goals and you have to study them longer.

Am I to assume that the HHS does not recommend any long-term health care legislation at this time?

Mr. SANDERS. At this time, we are not. We are in the process of studying that and will be moving forward with recommendations through the administration.

Mr. PICKLE. Do you recommend any kind of changes to the skilled nursing facility program?

Mr. SANDERS. We have an existing benefit in the Medicare program. We spend about $3.5 billion a year on that. We are not recommending expansions or contractions of that benefit.

Mr. PICKLE. I see.

Do you have any specific proposal or recommendation today other than just to comment on the bill that is before us and the problem we face?

Mr. SANDERS. No, I do not.

Mr. PICKLE. Well, HHS is not much help to us, then. We have waited 25, 27 years to provide long-term care benefits. Like most Members of Congress, I have always said that this is not the year, we just can't afford it, and basically that has been correct, too. There comes a time, though, when we have to try to do something.

I would imagine this should be the year we could start. But we need some leadership from HHS. You are just dealing with alarm and concern and looking at lofty goals, and wallowing in problems and not giving us any leadership.

I submit to you, sir, not you individually but to the Department, if we are going to find an answer, I think you have got to send some leadership from down the street and help us. This committee is not going to be able to move it forward and I don't know that the Congress will move it forward at all. But I think we have reached a point where we ought to try to do something.

So I just exhort you as an individual, go back and tell them we would like to see a little courage coming down the street rather than a cautious analysis.

Factually, you may be correct, but that doesn't cut the butter. We have got to do better than that.

Mr. SANDERS. I would be happy to take that message back.

Chairman STARK. Right on, Jake.

Mr. Sanders, am I to infer from your testimony that if I can find a way to pay for this, you would endorse H.R. 1200?

Mr. SANDERS. That would eliminate one major objection. I am not sure it would eliminate all the objections.

Chairman STARK. It wouldn't surprise you if you and I were somewhat apart on our cost estimates. You are looking at about a billion or two?

Mr. SANDERS. These are very, very preliminary estimates.

Chairman STARK. And we are thinking of $200 million.

Mr. SANDERS. And I think most of our estimate derives from the skilled nursing facility, 3-day prior hospitalization.

Chairman STARK. I understand that. This was a contentious difference between OMB and CBO during the catastrophic bill, so it doesn't surprise me there are some differences.

When do you expect the departmental task force to issue their recommendations on long-term care?

Mr. SANDERS. We don't expect them before the summer. We are awaiting and have stated we would be waiting for the Steelman Commission to report, and that will not occur until the summer.

Chairman STARK. Summer——

Mr. SANDERS. This summer.

Chairman STARK. 1991?

Mr. SANDERS. I believe that is the schedule for their reporting. It won't be before that. I am not committing HHS to this summer.

Chairman STARK. If I offered you an extra week's vacation, would you postpone your 1991 vacation until the Steelman report was out?

Mr. SANDERS. I am not sure that would be advisable.

Chairman STARK. Are you familiar with most of the data on what the average value of life insurance and the affordability of long-term care insurance is?

Mr. SANDERS. Generally familiar with those things.

Chairman STARK. Would you concur with me that there is not 20 percent of the population out there that would either have enough income or assets to afford it?

I will spot you whatever number you want, but even if we put those people off the table, there is still a large number of Americans who can't get into that arena.

Mr. SANDERS. I will grant you that that is true.

Chairman STARK. More than half.

Mr. SANDERS. Probably, but there is a second factor, and we are really looking at it as a long-term issue. The elderly, particularly those who are becoming elderly now are much better off than their predecessors. So we can expect older Americans to be better off in the future than they are now and to be better taken care of in their old age. Pensions are better.

Chairman STARK. Now, I really am going to try to trap you here, but if you can figure out how to do it, I would have been a lawyer instead of a banker. Are you talking here about the fact that a social insurance model does not target services according to their need, right? On page 5?

Mr. SANDERS. Yes.

Chairman STARK. Are you thereby suggesting that the only needs that we should be addressing here are income related?

Mr. SANDERS. I am not sure I am going that far, to suggest that I am saying——

Chairman STARK. What else?

Mr. SANDERS. I guess I am saying, there are concerns if you take the social insurance program approach. I think there are concerns with every approach. I will be the first one to admit, if there were an easy answer here, we would be moving ahead forward much more quickly than we have. But one concern is that by taking the social insurance route, you cover people who are of high-income as well as modest income. That adds to the cost that the taxpayer must finance.

Chairman STARK. But don't you feel that targeting services to clinically define needs is best met through a social program?

Mr. SANDERS. Targeting to clinically defined needs perhaps, but I think the social insurance program defines who is eligible, not services in particular.

Chairman STARK. You decide that eligibility how? By how much money they have, or whether they need the service?

Mr. SANDERS. I would argue both are almost equally important concerns.

Chairman STARK. If we are going to deny people services, directly or indirectly, if we must do that because of limited resources, would it not be better to deny the services to people who had the least clinical need rather than deny the services to the people with the least money?

Mr. SANDERS. I think you are doing a pretty good job at trapping me. I think you underestimate your lawyer ability. I think the answer to that is, it is appropriate to consider both of those things. It doesn't have to be an either-or proposition. It can be both.

Chairman STARK. Let me try that again. If we must limit certain types of care to people, wouldn't it be better having a doctor making the decision as to how to distribute those limited resources rather than have to distribute those limited resources based on who could least afford it?

Mr. SANDERS. Again, I may not give an answer that is going to satisfy you. I think clearly a doctor has to be involved in making that decision. I think it is also appropriate as we consider the broad problem, to apply both criteria or to consider both——

Chairman STARK. Which criteria would you apply first?

Mr. SANDERS. They are different.

Chairman STARK. You have two people with tummy aches. Both are in agony. Now, you have one doctor. Which person do you see first? You have a doctor there and I have a banker. Do you decide you take the wealthiest person first or the person most in danger of dying?

Mr. SANDERS. Clearly, you take the person who is most in danger of dying first. That does not go to the question of who pays for that.

Chairman STARK. I am not saying there may not be other choices, too. I just wanted to emphasize that because I think your testimony indicates that, when you say those most in need, you are talking about financial need, aren't you? I think that is one of the things that we overlook in this country too much, when we talk about rationing. They ration in Canada clinically. Neither poorer neighborhoods ration by income or lack of resource.

The question is as to which is better or worse. The SNF benefit proposal, if you are unable to provide the information today, would you provide an answer for the record based—one, based on 1989 data. How many persons would cover SNF stays on hospitalization? Do you have that with you?

Mr. SANDERS. I do not have it with me.

Chairman STARK. And then how many persons entered a hospital directly from a nursing home in 1988 and 1989.

You can get those for us.

[The information follows:]

A data match of December 1990 inpatient hospital and inpatient SNF MEDPAR files generated the following information. MEDPAR files include hospital and SNF stay records for Medicare beneficiare is based on billing information submitted by providers to fiscal intermediaries for payment.

(1) In calendar year 1989, there were 839,108 total SNF admissions. Of these, 576,979 had prior Medicare covered inpatient hospital stays of 3 or more days within 30 days of the SNF admission. In terms of the 807,857 Medicare covered SNF admissions, 561,601 had prior inpatient hospital stays of 3 or more days within 30 days.

(2) In 1988, 365,674 final discharge bills from SNFs were received. Of these 73,729 has inpatient hospital stays starting on the same day as the SNF discharge. An additional 6,311 were admitted to an inpatient hospital within 1 day of the SNF discharge.

The corresponding numbers for 1989 are: 620,655 SNF stays with final discharge bills; 125,458 admissions to a hospital on the same day; and 11,697 admission to a hospital within 1 day of the SNF discharge.

Oftentimes, the last bill from a provider does not indicate that the beneficiary was discharged. The above numbers include only those SNF stays were the last bill indicates that it is a final discharge bill.

Chairman STARK. In 1990 we passed legislation requiring HCFA to update the cost limits using 1988 data. I understand that the provision has not yet been implemented. Can you tell us why those cost limits haven't been updated and when we could expect the provision to be implemented as required?

Mr. SANDERS. Yes. The regulation has been prepared and it is awaiting final clearance at OMB. We don't expect it to take much longer.

The payment benefit is retroactive, so while it is——

Chairman STARK. With interest?

Mr. SANDERS. I am not sure about the interest.

Chairman STARK. Thank you.

Mr. SANDERS. Soon.

Chairman STARK. Mr. Moody would like to inquire.

Mr. MOODY. Thank you.

I apologize if I ask anything the Chairman asked before I came back to the room. I see on page 5 of your testimony, you say a very preliminary cost estimate indicates increased expenditures of at least $1.2 billion mostly due to your evaluation of the SNF prior hospital stay repeal.

Do you take into account the unnecessary hospital stays that are created to qualify people? Is there a way of offsetting that? Can you offset that amount? Because clearly we know that is going on.

Mr. SANDERS. I don't think we clearly know that so well.

Mr. MOODY. We have heard anecdotal evidence that doctors are sympathetic and let people meet that requirement.

Mr. SANDERS. Let me stress, these are very preliminary estimates. This is a very complicated area. We are working with folks

to understand it a little better and understand what happened in catastrophic a little better.

But on a preliminary basis, we don't assess any offset because we think it would be minimal. Again, there are restrictions in our program that don't allow patients to go into the hospital unless that is medically necessary.

Mr. MOODY. That is the theory, but that is a discretionary call, and generally sympathetic to the patient's problems.

We can't sit here and say it doesn't happen. We know it is a nonzero and I suspect a nontrivial number. You are assigning a zero number to it. Zero is not the right number, and I can't tell you what the right number is. But we need to put a strong caveat on any number that you put in there.

Mr. SANDERS. I think we are planning on looking at this much more closely and maybe at some point changing the number from preliminary to a firm cost estimate, at which point we will be prepared to defend the specific assumptions in much more detail than I am today.

Mr. MOODY. If, for example, their behavior was X, then that need back or that offsetting number would be Y. If, let's say, 10 percent of the cases, doctors—you know what I mean by sensitivity analysis, and the cost benefit jargon? Where we simply pick a point estimate, give us some behavioral parameters about what the cost would be if the range was in some reasonable limit.

It is not a corner solution, but it is where along the spectrum would it be, and the sensitivity calculation would be much appreciated.

Mr. SANDERS. Yes, sir.

Mr. MOODY. Thank you.

Chairman STARK. Thank you very much.

We are very pleased to welcome representatives from three consumer organizations. Dr. Margaret Dixon represents the American Association of Retired Persons and is a member of AARP's board. Ms. Dixon is from Upper Marlboro, Md.

Max Richtman is the director of government relations on the National Committee to Preserve Social Security and Medicare.

Mr. Keane is cochair to the Public Policy Committee of the Alzheimer's Association.

I welcome the panel here and we will ask Dr. Dixon to lead off.

STATEMENT OF MARGARET DIXON, MEMBER, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS

Ms. DIXON. Thank you, Chairman Stark.

My name is Margaret Dixon and I am a member of the board of directors of the American Association of Retired Persons [AARP]. On behalf of our membership, I want to commend you for holding this hearing and, by doing so, for advancing the congressional and public debate on health and long-term care.

AARP shares your strong commitment to protect persons of all ages against the serious problem of long-term illness and disability.

There are countless examples of people whose lives and dreams have been shattered by poor access to needed care. Each of us is just as vulnerable. Comprehensive reform of our health care

system must become a national priority if we are to reach the goal of assuring access to quality care for all our citizens and gain control of escalating health care costs.

For most people, the cost of long-term care is an unmanageable financial burden. An estimated 81 percent of annual out-of-pocket expenses, over $2000 incurred by elderly persons is spent on long-term care.

With average annual nursing home costs of $30,000 and home health care costing from $50 to $200 per day, long-term care out-of-pocket costs are extraordinary. We must recognize that in addition to these costs, there are significant indirect costs that exact a heavy price on those effected—a mother, for instance, who has sacrificed a career, including Social Security and pension benefits, to help her own mother or child who needs long-term care due to a disability or illness. These costs need to be taken seriously.

The need for long-term care among persons of all ages, the burden on families and impoverishment establish the need for a better approach to long-term care.

AARP recommends a social insurance approach similar to the medicare and social security programs that protects all Americans from impoverishment and lack of care. Social insurance would spread the burden so that the cost to any one person would be small while offering protection and appropriate care to all.

Surveys have demonstrated that the public is willing to participate in and pay for a social insurance approach if the program provides the benefits that they view are needed most. The longer we wait, however, the higher the cost will be.

The private sector has an important supplementary role to play in providing protection, just as our private pension system builds on social security as its base. Numerous limitations, however, such as a prohibitively high cost make it impossible for long-term insurance to form the primary basis for a solution.

Under a social insurance system, private sector approaches should supplement the public system by covering copayments, deductibles, and extra services. All private sector approaches should include strong federally mandated consumer protection standards.

We commend you, Mr. Chairman, for developing the Mediplan Long-Term Act of 1991, a comprehensive long-term plan which succeeds in addressing the primary concerns of the members of the AARP.

The association would also like to commend you for the recent introduction of legislation to eliminate the Medicare skilled nursing facility three-day hospitalization requirement, and to improve the current Medicare home health program.

Concerning the skilled nursing facility Medicare program benefits, there are many problems. The Catastrophic Coverage Act addressed some of these problems, but these important provisions were unfortunately repealed.

AARP supports enactment of these provisions, including reducing the disproportionately high coinsurance amount. Currently, the coinsurance is $78.50 after the 20th day of care, and this often exceeds the cost of a day of care in the skilled nursing facility.

Mr. Chairman, I appreciate the opportunity to address the committee today. AARP stands ready to work with you and with your

colleagues in achieving the goal of comprehensive and affordable health care for all Americans.

[The prepared statement follows:]

TESTIMONY OF MARGARET DIXON
AMERICAN ASSOCIATION OF RETIRED PERSONS

Thank you, Chairman Stark. My name is Margaret Dixon and I am a member of the Board of Directors of the American Association of Retired Persons (AARP). On behalf of our membership, I want to commend you for holding this hearing and, by doing so, for advancing the Congressional and public debate on health and long-term care. AARP shares your strong commitment to protect persons of all ages against the serious problem of long-term illness and disability.

Our nation can be proud of our achievements in health care, and we should not continue to allow these achievements to be diminished by our failure to guarantee all citizens access to basic acute and long-term care services. Undoubtedly, the phenomenal increase in health care costs is a substantial barrier to access, extending across all age groups and income brackets. There are countless examples of people whose lives and dreams have been shattered by poor access to needed care. Each of us is just as vulnerable. Comprehensive reform of our health care system must become a national priority if we are to reach the goal of assuring access to quality care for all our citizens and gain control of escalating health care costs.

AARP has adopted principles for health care reform addressing both acute and long-term care. These principles (included at the end of our written testimony) establish a framework for achieving health care reform. AARP believes that to achieve meaningful health care reform, Congress must establish a blueprint--the broad architecture--of a reformed system that reflects these principles.

Because there is not a consensus on the nature of our nation's health care problem, we too often take a piecemeal or "band-aid" approach. Year-after-year we have added levels of complexity to our already fragmented health care system, resulting in perpetual cost-shifting and increasing administrative costs. The problems caused by piecemeal solutions are quite evident in long-term care, where we have no logical "system" for protecting against long-term care costs. All Americans are at risk of needing long-term care, but neither Medicare nor private insurance has sufficiently pooled this risk, leaving Americans of all ages in jeopardy of losing their life savings and of receiving inadequate care.

In addition, the diversity of demands on the Medicaid program is making it increasingly difficult for that program to carry out its mandate--to provide basic health care services for low-income individuals at the same time that it provides long-term care services to older Americans.

Clearly, we need to develop a consensus around a comprehensive health care reform plan in order to not only achieve access for all but also real cost control. Only when we take this step can we have confidence that all Americans will have access to the quality, affordable acute and long-term care that they need.

My testimony today will discuss the cost and access problems that beset our nation, as well as why the long-term care crisis must be addressed. I will also discuss AARP's preferred approach to resolving this crisis; how your legislation, Mr. Chairman, addresses many of our concerns; and what productive interim steps might be taken in the short term.

Health Care Costs

The escalating cost of health care in America is one of the most significant problems of our current health delivery system. No aspect of our society remains unaffected. The uninsured and underinsured, public and private payers of health care as well as the insured are adversely affected by rising health care costs.

From 1980 to 1989, national health expenditures for nursing homes increased 140 percent. In 1989, out-of-pocket expenditures accounted for 44 percent of expenditures for nursing home care, Medicaid contributed 43 percent, Medicare covered eight percent and private insurance paid for only one percent of the costs. (Note: Prior to 1989, Medicare spending accounted for only one to two percent of nursing home expenditures. In 1989, however, changes made in the Catastrophic Coverage Act contributed to an appreciable increase in Medicare's share of the nursing home bill.)

An estimated 81 percent of annual out-of-pocket expenses over $2,000 incurred by elderly persons is spent on long-term care. With average annual nursing home costs of $30,000 and home health care costing from $50 to $200 per day, long-term care out-of-pocket costs are often truly catastrophic.

We must recognize that in addition to these costs there are significant indirect costs that exact a heavy price on those affected. A mother, for instance, who has sacrificed a career to tend to her child who needs long-term care due to a disability or illness. Health care statistics do not account for the years of forgone income, pension and Social Security benefits that this mother, and others like her, will experience. These costs need to be taken seriously in the context of meaningful health care reform.

Access to Health Care

Escalating health care costs are directly linked to the decline in access to health care coverage in America. Aside from the pervasive lack of long-term care protection, approximately 34 million Americans under the age of 65 and 300,000 over the age of 65 have no insurance for essential acute care needs and millions more have inadequate insurance protection.

The lack of a comprehensive federal program also contributes to access barriers. Even given its limited coverage, the Medicare program, for instance, still has significant gaps in coverage and the required copayments are more than some elderly can afford. The absence of meaningful public or private coverage for home and community-based services creates incentives to place individuals in nursing homes when other alternatives would be preferable. The only Federal program which provides real coverage for nursing home care-- Medicaid--forces individuals to deplete their life savings before they can receive benefits.

The Medicaid program, which was intended to serve as the "safety net" for our nation's low income population, is severely limited. Such welfare-based programs typically place unreasonably restrictive income and asset eligibility requirements on groups and impede access because of administrative barriers in the application process and the stigma attached to it. In addition to constant budgetary constraints, a means-tested program does not receive the broad public and political support granted to social insurance programs like Social Security and Medicare.

Comprehensive health care reform, which includes long-term care, would significantly reduce many of the health care access problems associated with our current system. AARP believes that individuals of all ages have a right to receive quality health care services when they need them, and that the public, through the federal and state governments, has the ultimate responsibility to develop a system that ensures reasonable and equitable access to needed services. The long-term care crisis should be addressed through broad-based, social insurance financing where everyone contributes his or her fair share in return for guaranteed access.

The Need for Long-Term Care

Everyone is at risk for needing long-term care, not just older persons. While approximately 1.5 million elderly and 0.2 million people under 65 live in nursing homes, over 5 million disabled elderly and over 3 million disabled younger people live at home or in other community settings. Many of these chronically ill children and adults who need long-term care are not eligible for Medicare or assistance from Social Security. The need for assistance extends beyond those who need the care to those--family and friends--who provide personal care and financial support. Family members provide the vast majority of long-term care needed by older persons. These caregivers, typically wives and daughters, often provide care every day, with great physical, emotional and financial sacrifice.

For most people, the cost of long-term care is an unmanageable financial burden. Many families are also shocked to find--only too late--that neither Medicare nor private insurance covers long-term care to any great extent. Fully one-half of the general public and one-third of older Americans erroneously believe that their private insurance or Medicare will cover their long-term care bills, respectively.

Perhaps most important of all is the hidden cost associated with the unavailabilty of assistance--the suffering, deprivation, and isolation for those in our society who get no care or inadequate help. Data from the National Long-Term Care Survey indicate that large numbers of functionally impaired older persons in the community, particularly the severely disabled, have unmet needs for assistance. For example, 77 percent of older people with three or more limitations in their activities of daily living reported they needed more help than they were getting.

These factors--the need for long-term care among persons of all ages, the burden on families, impoverishment, and lack of care--demonstrate the need for a better approach to financing and delivering long-term care. AARP recommends a social insurance approach, similar to the Medicare and Social Security programs, that protects all Americans from impoverishment and lack of care. Social insurance would require financial contributions from all members of society and would provide protection to all who need long-term care. Such an approach would spread the burden so that the costs to any one person would be small, while offering protection and appropriate care to all.

Americans of all ages recognize that long-term care protection is a growing necessity. Given demographic trends--with baby boomers aging, mortality rates falling and worker-to-retiree ratios declining--the longer we wait, the more expensive a solution will be. While many underestimate the costs and the likelihood of their needing services (one in three persons will need nursing home care at some point in their lives), surveys have demonstrated that the public is willing to participate in and pay for a social insurance approach if the program provides the benefits that are needed most. A survey conducted in November, 1989 for AARP by the Daniel Yankelovitch Group, for example, found that Americans are willing to pay increased taxes for a long-term care package that would provide comprehensive coverage for all Americans. The findings in this study highlighted the need for nursing home care as part of a long-term care package--primarily because it is the cost of nursing home care which individuals fear the most when they consider their long-term care needs. However, until a specific package of benefits and financing are put together, such conclusions are tentative at this point.

Financing the New Long-Term Care Program

A long-term care program that covers people who currently need services and builds an adequate program for future generations will require a range of financing sources. AARP believes that a financing package should take into account the fact that many disabled people would be eligible for benefits before a large reserve fund could be built up. Therefore, benefits should be phased-in.

Older Americans and the working population will each have to pay a portion of the costs of a long-term care program, both in its early phase and for future generations. Revenue from older Americans could come from sources such as higher estate and gift taxes. Modest premiums might be used, but an actuarially sound contribution to buy protection against long-term care costs is simply too expensive for most older Americans. Since any system would likely have some cost-sharing requirements (copayments and deductibles), older Americans would be asked to contribute in this way. Such cost-sharing should, however, reflect the fact that they are already paying substantial premiums for acute care protection under Medicare.

Revenue sources, such as payroll or other dedicated taxes, should be earmarked to a trust fund to build adequate reserves to protect younger generations. Other options for raising revenue, in addition to those which might be earmarked, include increasing income tax rates, broadening the income tax base, and increasing estate and gift taxes. These methods would allow substantial reserves to accumulate and ensure benefits for the "baby boom" generation. To help defray the federal government's costs, the new long-term care program should also incorporate some level of state spending.

The Association opposes efforts to condition eligibility for the program's long-term care benefits on income or assets. Any beneficiary cost sharing for either community or institutional services should be modest. Coinsurance and deductible amounts should not vary by income. Varying these amounts would be administratively complex and costly. People with low incomes should be protected against cost sharing through an expanded Medicaid-type program, which could be partly financed through general revenues.

The Role of the Private Sector

The private sector can and should play an important supplementary role in helping to provide protection against the cost of long-term care. Private sector options for financing long-term care include long-term care insurance, home equity conversion plans, and the prospect of long-term care individual medical accounts. Although long-term care insurance offers some promise as a way to augment a federal social insurance program it is still in its infancy and there are major barriers to its development. While the number of policies sold (estimated at about 1.6 million) is growing, they cover few of the 51 million Americans aged 55 and over.

Projections using the Brookings-ICF Long-Term Care Financing Model indicate that by 2018, insurance may be affordable by 25-54 percent of the elderly and may finance 7-17 percent of total nursing home expenditures, given favorable assumptions. This finding is based principally on barriers that are likely to limit the usefulness of long term care insurance policies to the public. Such barriers include:

- o the prohibitively high cost of policies that provide meaningful protection;
- o serious limitations and restrictions in coverage;
- o high "lapse", or drop-out rates, with no non-forfeiture protection;
- o the lack of adequate inflation protection;
- o the lack of meaningful home care benefits, and;
- o consumers' lack of knowledge about the need for protection against long-term care expenses.

In addition, people in need often are prohibited from purchasing private long-term care insurance. Few companies will sell insurance to people age 80 or over, or to people with pre-existing (potentially disabling) medical conditions. This practice may be necessary to maintain the financial stability of the insurance plan, but it leaves those most likely to need long-term care without any protection.

Due to these limitations, AARP believes that the primary answer to the long-term care financing dilemma lies with public, not private insurance. Under a social insurance system, private sector approaches should supplement the public system by covering copayments, deductibles, extra services and services for those not eligible for government program benefits. The analogy we would draw is with Social Security and private pensions: Social Security provides the base or foundation on which private pensions--for those who are fortunate to have them--are then based. All private sector approaches should also include federally mandated strong consumer protection standards.

Mediplan Proposal

AARP commends you for developing the MediPlan Long-Term Care Act of 1991, a comprehensive long-term care plan which succeeds in addressing the primary concerns of the members of AARP, as expressed in our attached long-term care principles.

In particular, the Association is pleased that your proposal:

- o provides access for all Americans, regardless of age or income, to a broad range of long-term care services, such as nursing home, home health and community-based care;
- o spreads the cost of long-term care across the entire population;
- o ensures an orderly development of this new program through a phase-in period;
- o assures reasonable payment to long-term care providers;
- o maintains quality assurance by including standards and conditions of provider participation; and
- o provides for care management and reimbursement rules that focus on cost containment.

The Association would also like to commend you for the recent introduction of legislation to eliminate the Medicare Skilled Nursing Facility (SNF) three-day prior hospitalization requirement and to improve the current Medicare home health program. My remaining remarks will address such important incremental reforms.

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The Need for Medicare SNF Reform

Although AARP would prefer to see a comprehensive, universal social insurance long-term care proposal enacted as soon as possible, we recognize that meaningful incremental steps toward that eventual goal may be more realistic. The current SNF Medicare program benefits, for example, mislead consumers and are largely illusory. The Catastrophic Coverage Act addressed these problems, but these important provisions were, unfortunately, repealed. AARP supports reintroduction and enactment of these provisions. We support, for example, elimination of the three-day prior hospitalization requirement in order to increase Medicare beneficiaries' access to this benefit. A May 1989 study for the Department of Health and Human Services which estimated that 20.1 percent of short stay hospitalizations were unnecessary also raises questions regarding whether patients are being hospitalized for the purpose of qualifying for SNF care.

However, safeguards should be in place to contain costs and prevent the indiscriminate transfer of Medicaid and other current residents to Medicare beds in order to qualify for Medicare SNF coverage. Recent changes in nursing facility resident rights that specifically prohibit moving residents for the purpose of qualifying for SNF beds without their permission will address part of the problem. Additional steps might be taken to make new benefits available only to new admissions.

If, given current budgetary constraints, it would not be possible to go as far as the Catastrophic Coverage legislation did in reducing the coinsurance amount and moving it to the first eight days, we would be supportive of reducing the coinsurance amount over time so that it equal to 20 percent of per diem SNF program costs. Currently, the coinsurance amount is $78.50 for days 21-100. The amount is equal to one-eighth of the hospital deductible, which is computed to represent the average cost of one day in the hospital. The linkage of the cost of SNF care to that of hospital care has resulted in cases in which the coinsurance amount **exceeds** the cost of a day of care in a SNF. This excessive copayment requirement effectively has reduced already very limited coverage to a maximum of only 20 days.

The Need for Expanded Medicare Home Health Care

The Association also supports expansion and clarification of the Medicare home health benefit as a first step toward more comprehensive coverage. Currently, the scope and accessibility of Medicare home health coverage is limited. This limitation has largely stemmed from an inconsistency in the interpretation of the definition of intermittent care. Some intermediaries have interpreted intermittent to mean four days or less per week. As a result, beneficiaries who need skilled home health care more than four days a week are often denied coverage.

AARP supports clarifying the definition of intermittent care to cover care that is needed or given six or fewer days per week, and to cover short-term care needed seven days a week for at least thirty-eight consecutive days. By expanding and clarifying the Medicare home health care benefit, beneficiaries will have greater access to the home care they need.

The Need for Respite Care

The Association believes an important step toward comprehensive reform is a respite care benefit. Currently, among older Americans who need long-term care services, fewer than one in five receive this care in a nursing home. The remainder continue to live in their communities and depend on a network of informal caregivers for their care. Roughly three-quarters of disabled older persons who are not in nursing homes depend solely on this type of informal care.

The burdens on those who provide informal long-term care--both financial and emotional--are tremendous. One-third of family caregivers are over the age of 65 themselves. Many have family income below or near the poverty threshold and describe their own health as relatively poor. Others, notably women, must balance the competing demands of their own families with their caregiving responsibilities. Almost one-half of adult daughters providing care to older parents are employed outside the home, and one-quarter have children under the age of 18. A meaningful respite care benefit would provide significant relief to these over-burdened caregivers, permitting them to continue caring while maintaining their own livelihood, health and peace of mind.

Financing Incremental Improvements

It should come as no surprise that, given the road that you and we have travelled over the last several years, beneficiary-only financing is not what AARP would want to see used for future benefit expansions. The Association views the traditional financing of Medicare--which spreads the cost of the program across the entire population--as a fundamental tenant of the Medicare program which should not be breached lightly.

However, improvements to Medicare provided by this legislation are very important to older Americans and the response from our own membership reinforces this. As AARP weighs the importance of these benefits against concerns about Medicare beneficiaries' ability to shoulder this increased financial burden now and in the future, we view premium-only financing as an extraordinary step that is acceptable only if the premium increase is small.

CONCLUSION

AARP believes that containing health care costs and guaranteeing all Americans access to affordable, quality acute and long-term care must be a national priority. In discussing this issue with AARP members nationwide, we have found that continued public education will be essential for building consensus on this important issue.

Comprehensive reform of our health care system will only be possible when the American people understand the need for protection and recognize the inherent danger involved in continuing a piecemeal approach to a comprehensive problem. Clearly, the 1992 Presidential and Congressional elections will offer an important opportunity to engage in a national debate that can help solidify America's commitment to health care reform.

Long-term care is an integral part of this growing national crisis that will touch nearly every American family. Millions of families are vulnerable to financial ruin from the devastating cost of long-term care. Most tragic of all is the deprivation and isolation of those who get inadequate care or no care at all.

The only fair way to provide all Americans with affordable protection from the devastating costs of long-term care is a broad-based social insurance program into which everyone pays and from which all are eligible to benefit. A social insurance program will make paying for long-term care predictable and affordable. By doing so, it will promote dignity and independence and make it possible for families to avoid the financial disasters that presently accompany chronic illness.

Mr. Chairman, I appreciate the opportunity to address your Committee today. AARP stands ready to work with you and your colleagues in achieving the goal of comprehensive and affordable health care for all Americans.

HB3-W&M-3/1

Preamble

AARP believes that the United States has the resources to ensure access to acute and long-term care for all individuals, and to control health care costs without compromising quality of care. Efforts to reform the health care system must recognize the need to provide acute and long-term care over the course of an individual's lifetime. AARP recognizes that advancement may be achieved in incremental steps, but we believe that each of these steps should move the country closer to the goal of comprhensive, affordable acute and long-term care for people of all ages.

The following sets of principles are designed to guide the Association in its efforts to reform our current acute and long-term care systems. The principles do not address every specific issue relating to health care reform, but they do establish criteria for evaluating and comparing reform proposals. They also serve to guide the Association in its participation in the public debate over health care reform.

Acute Care Principles:

1. All individuals have a right to receive health care services when they need them.

   The public, through the federal and state governments, has the ultimate responsibility to develop a system that ensures reasonable and equitable access to needed health care services for all individuals.

2. All individuals have a right to reasonable access to health care coverage that provides adequate financial protection against health care costs.

   The public, through the federal and state governments, has the ultimate responsibility to develop a system that ensures universal access to health care coverage for all individuals, including individuals with disabilities or health problems. The health care system should be designed to ensure that all individuals are covered by a public or private health coverage plan. The government should establish a minimum benefit package to which all individuals are entitled.

3. All individuals have a right to high quality health care.

   The health care system should collect, analyze, and disseminate information about provider performance, health care outcomes, and the appropriateness and effectiveness of health care services. Quality assurance programs, such as peer review and professional licensure, should be strengthened and coordinated.

4. All individuals should have a reasonable choice of health care providers.

   Cost containment efforts should not unreasonably limit choice of providers. Consumers should be provided with sufficient information about health care providers and treatment options to make informed health care decisions.

5. Financing of the health care system should be equitable, broadly based, and affordable to all individuals.

   Government, employers, and individuals share the responsibility to participate in health care financing.

Our present method of financing health care should be replaced by fairer, more progressive financing approaches. Burdensome cost-sharing requirements (e.g., burdensome deductibles and coinsurance) should be avoided because they disproportionately affect the sick and the poor. The public, through the federal and state governments, should subsidize the cost of health care coverage for individuals with lower incomes and should fully finance health care coverage for the poor. Any financing method should preserve the dignity of the individual, regardless of his or her income level.

6. Methods of provider reimbursement should promote cost containment, encourage efficient service delivery, and compensate providers fairly.

   Health care providers should receive basically the same reimbursement for the same services within a given area, regardless of the payment source. The government should play a major role in establishing more uniform reimbursement practices and rates for health care providers. Health care providers share in the responsibility to be fiscally prudent.

7. Health care spending should be more rational and should be managed through more effective planning, budgeting, and resource coordination.

   The distribution and allocation of health care resources (e.g., capital, technology, and personnel) should encourage innovation, efficiency, and cost effectiveness, and should promote reasonable access to services. Federal and state governments should play a major role in planning and coordinating the allocation of health care resources.

8. Health promotion and disease prevention efforts should be strengthened.

   The public health system (e.g., water and sewer service, environmental protection, occupational safety, etc.) should be strengthened to ensure the public's health, safety, and well-being. Public health efforts should: (1) increase citizen understanding and awareness of health, environmental and safety issues and problems; (2) improve access to primary and preventive care services, such as maternal and child health care, immunizations, and nutrition counseling; (3) conduct health, environmental, and safety-related research; (4) coordinate the collection and dissemination of information about health, environmental, and safety issues; and (5) assure compliance with health, environmental, and safety standards.

9. Individuals share a responsibility for safeguarding their health by educating themselves and taking appropriate preventive measures to protect their health, safety, and well-being.

   The government, health care providers, and consumer organizations share in the responsibility to educate the public about health care. Differentials in contributions for health care coverage to encourage healthy behavior can be appropriate as long as they do not deny access to health care.

10. The acute and long-term care systems should be coordinated to ensure a continuum of care across an individual's lifetime.

Preamble

AARP believes that the United States has the resources to ensure access to acute and long term care for all individuals, and to control health care costs without compromising quality of care. Efforts to reform the health care system must recognize the need to provide acute and long term care over the course of an individual's lifetime. AARP recognizes that advancement may be achieved in incremental steps, but we believe that each of these steps should move the country closer to the goal of comprehensive, affordable acute and long term care for people of all ages.

The following sets of principles are designed to guide the Association in its efforts to reform our current acute and long term care systems. The principles do not address every specific issues relating to health care reform, but they do establish criteria for evaluating and comparing reform proposals. They also serve to guide the Association in its participation in the public debate over health care reform.

Long Term Care Principles:

1. Long-term care services should be **available to all** people who need them, regardless of age or income. The long-term care program should base eligibility for services on a person's physical and cognitive functioning, including limitations in performing activities of daily living (e.g., eating, bathing and dressing) and a person's need for supervision. Uniform, national assessments should determine whether a person meets the eligibility criteria for the program and the type and level of care that a person needs.

2. A national long-term care program should provide a comprehensive **range of services.** These services should include: (1) in-home assistance; (2) community services; (3) long-term care services in a full range of supportive housing options (4) institutional care; and (5) rehabilitative services. Long-term care should be provided in the least restrictive setting possible.

3. The new public program should assist, not replace, current informal **caregivers.** Families and friends need access to supportive services so that they are not unreasonably burdened and can continue to provide care. The services should include respite care, adult day care, and other types of assistance, such as an expanded dependent care tax credit.

4. Implementation of the public program must be **phased-in** to ensure orderly development of the new system. Expansion of services should be accompanied by development of a long-term care infrastructure, including health care personnel, that will permit the delivery of a comprehensive range of home, community and institutional services.

5. The principles of **social insurance** (e.g., Social Security or Medicare), and shared risk must be extended to long-term care. Under social insurance programs, individuals pay into the system and are then entitled to benefits when they are needed. By spreading the cost across the entire population, universal protection can be achieved in an affordable, equitable manner for everyone.

6. **The new long-term care program should be financed primarily through taxes earmarked to a trust fund.** Revenue sources could include payroll taxes, increased estate and gift taxes, income taxes and modest premiums. The new public program must be financed through taxes and premiums so that it does not increase the federal deficit.

7. **The new public program must provide a solid foundation for protection,** upon which the private sector can build. The private sector could supplement the public program by covering the program's copayments and deductibles, as well as services that the public program does not provide. Any private sector approach (e.g. long term care insurance) should be subject to strong standards to protect consumers from inadequate products.

8. **Payment to providers** of long-term care services must be reasonable and provide financial returns to providers who deliver quality care. Reimbursement systems for home, community, and institutional care must respond to clients' needs, promote delivery of quality care, and recognize the outcomes of care provided to clients.

9. **Cost containment** mechanisms must be built into the new long-term care system. Use of services could be controlled by providing a defined set of services to beneficiaries. Modest deductibles and copayments also should be included. However, people with low incomes should be protected.

10. The federal and state governments should assure delivery of **quality care** under the new long-term care program. Recent improvements in the quality assurance systems for nursing homes and home health agencies should be swiftly and vigorously enforced. In addition, new methods of assuring the quality of other home and community services must be found.

Chairman STARK. Thank you, Dr. Dixon.
Mr. Richtman.

STATEMENT OF MAX RICHTMAN, DIRECTOR OF GOVERNMENT RELATIONS, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Mr. RICHTMAN. My name is Max Richtman. I am the director of Government Relations for the National Committee to Preserve Social Security and Medicare. On behalf of our 5 million members and supporters from around the country, I appreciate the opportunity to appear before this subcommittee to express our views on issues pertaining to long-term care coverage.

I am a little reluctant to do this, but before I get into my prepared comments, I wanted to say a few things about the discussion that took place here earlier today regarding catastrophic. As I listened to the Members of the subcommittee and witnesses talk about the catastrophic coverage act, it seemed like the discussion centered on the lessons of catastrophic. What did Congress learn, what did some of the groups that were involved learn?

I noted Congressman Moody's point about benefits lagging behind financing. Perhaps, that was a lesson that we all could learn from.

Congressman Gradison's point about whether the program was voluntary or mandatory in terms of participation, doesn't that represent a lesson?

I think there are certainly many lessons we learned in the catastrophic debate when it was enacted and after it was repealed. But I think the primary lesson is education.

I think that Congress and the groups it works with in developing a health care initiative from this point forward have to make sure that beneficiaries understand what benefits are included and what benefits are not included. They have to make sure beneficiaries are clear on what the financing mechanism is, meaning that the cost be fairly distributed among all people.

I know that in focus groups and meetings, surveys and policy discussions that the national committee conducted during the debate on catastrophic, it was clear that seniors did not understand what this legislation was all about. The vast majority of them believed that nursing home coverage was included.

Frankly, they were shocked to find out it was not, shocked and disappointed.

I think that is one of the major lessons in my mind, is that all parties involved in improving health care make sure that the beneficiaries, whether they are seniors or all of the American people, are clear on what it is that we are all talking about.

Chairman STARK. Max, rarely would I disagree, but you are wrong.

I have a very high-priced consultant who is advising me on those things, my mother. After trying to explain it to her for a long time, I decided the best policy is to lie to her. It works much better.

Other than that, proceed.

Mr. RICHTMAN. You are the Chairman, so I will defer on that point.

The need for long-term care for seniors and disabled Americans of all ages is well documented. The national committee has made it among its highest priorities to work towards a national health care system that provides universal coverage of all Americans, includes long-term, care, and is supported by broad-based social financing. A comprehensive and coordinated long-term care system that covers all aspects of care—nursing home care, home health care and community-based care—is the protection most seniors need and want. This is confirmed by our latest survey dated March 31, 1990, that indicates expanding Medicare to pay for long-term care and home health care to be a high or medium priority for 80 percent of our national committee members.

You, Mr. Chairman, have been one of the most outspoken supporters for a comprehensive long-term care plan, and we thank you for your efforts. With the introduction of H.R. 651, the Mediplan Long-Term Care Act, you have put forth a comprehensive plan that addresses the long-term care needs of our elderly and chronically ill citizens of all ages. It is sure to enhance the ensuing long-term care debate and move it in the right direction, toward enactment.

The Mediplan Long-Term Act is clearly one of the most far-reaching long-term care proposals introduced in the Congress. It addresses two of the fundamental needs of seniors in terms of long-term care: One, the need to prevent the very real threat of complete impoverishment due to an extended nursing home stay and, two, the urgent need of improved home health care and necessary coverage of community-based services.

Among our membership, we hear that their biggest fear is the idea of being confined to a nursing home for the remainder of their lives, and second, the fear of being impoverished as a result. We want those fears alleviated. H.R. 651 addresses these concerns.

Under H.R. 651, individuals requiring assistance with three or more activities of daily living [ADL's] would be eligible for unlimited nursing home care. Only a 20 percent copayment is required after a 2-month deductible is achieved for those with incomes over 200 percent of the Federal poverty level.

All persons falling below the eligibility standard of 200-percent poverty level would receive free care. At the average nursing home cost of $35,000 a year, the individual in need of nursing home care for several months or years, we believe, would generally find this to be a cost-effective benefit. For those who would find it difficult to pay the deductible and copayments, we would recommend that long-term care insurance be expanded to cover the "gaps" in coverage much like the current medigap insurance fills in the gaps of Medicare. Such a plan would provide the protection that so many of our seniors and severely-disabled Americans desperately need today.

We welcome, as well, the improvements in H.R. 1200 in regards to extending the home health care benefit under Medicare from 21 to 38 days. In addition, we view the proposed elimination of the 3-day prior-hospitalization requirement to be a significant improvement not only from a senior perspective but from a cost-saving one as well.

Clearly, a senior who may be dehydrated or malnourished due to depression or lack of attention in the home, would be a prime can-

didate for rehabilitation through intravenous treatments in a nursing home. In these types of cases the nursing home stay would be temporary. The beneficiary would be alleviated from the stress associated with repeated, unnecessary admissions to the hospital, and Medicare would achieve significant savings as a result.

Likewise we are encouraged by the inclusion in the plan of beneficiary protections such as case management assessments designed to keep costs down and the prohibition of extra billing by providers.

The financing of such an ambitious plan is always contentious and debatable. The national committee has consistently endorsed a social insurance model for the purpose of financing long-term care. We do so because we believe this to be the most equitable approach to providing a benefit that everyone could use. We will be polling our members in the near future about the various models and proposals currently being discussed. However, it is clear that the cost of any social insurance approach to long-term care financing must be evenly and fairly distributed among all segments of society.

In closing, the National Committee to Preserve Social Security and Medicare wants to reiterate its strong support for the improvements and are the focus of today's hearings. We look forward to working with you as the discussion and debate continues on comprehensive long-term care coverage. Thank you.

Chairman STARK. Thank you.

Mr. Keane.

STATEMENT OF BILL KEANE, COCHAIR, PUBLIC POLICY COMMITTEE, AND MEMBER, BOARD OF DIRECTORS, ALZHEIMER'S ASSOCIATION

Mr. KEANE. Thank you, Mr. Chairman.

Let me join the others in commending you for holding this very important hearing today.

If I could make just one point, it would be that long-term care must stay at the top of the national agenda.

It is already a crisis for millions of American families. Within our lifetimes it will overwhelm our health care system if we do not address it responsibly now.

I appear before you today as cochair of the Public Policy Committee on the Alzheimer's Association. I am privileged to speak for the 4 million Americans and their families who today confront the tragedy of Alzheimer's disease as well as those who suffer from related disorders.

We work through over 200 chapters, 1,600 support groups and more than 30,000 volunteers like myself in every part of the country.

Long-term care, along with research, is the top public policy priority for the association.

I also appear before you as a caregiver. My family has been through the experience of Alzheimer's disease, not once but twice over the last 15 years.

Alzheimer's disease is the quintessential long-term care problem: It is a devastating degenerative disease.

It takes a person you know and love, and robs her of everything—memory, judgment, personality, dignity—that made her a unique human being. That disease is irreversible, largely untreatable, and inevitably fatal.

I would like to take a moment to tell my family's story, not because it is special, but because it is all too typical of the long-term care crisis in this country.

In 1975, I was working in Upper New York State. My parents were retired and living in suburban Philadelphia.

I came home to visit, and found things in chaos. My mother, who had managed our household with care and efficiency for more than 40 years, could not figure out how to do the laundry or fix even a simple meal. Dad was trying to cover up for her, denying that anything was wrong.

They finally agreed to see a doctor, and after extensive testing, the diagnosis came back. My mother had Alzheimer's disease.

Mother deteriorated rapidly. Doctors told us she probably had only a year or two to live. We tried to keep her at home, but that became impossible.

Dad simply could not cope. I moved back home, but I had to work during the day. And there were no services available to help us in the county where we lived: no home care, no day care, nothing that would give us even a short break from the constant demands of caring for Mother.

We had no choice but to move her to a nursing home, where she lived for almost 10 years. We paid the nursing home more than a quarter of a million dollars, everything my parents had saved for their retirement years.

In a way, I suppose, we were lucky: Dad had been a Federal employee for 25 years. He had a good pension, and throughout their working years, he and mother had put away money "to see the world."

Things didn't work out the way they had planned, but at least there was money to pay for decent care. Not many people have enough money to do that today.

Alzheimer's killed both of my parents. Dad actually died 2 years before my mother, worn out physically, emotionally, and financially.

That is not the whole story. In 1978, while we were coping with my mother's care, her older sister was diagnosed with Alzheimer's.

Aunt Maggie had never married, and I was responsible for arranging her affairs. She had no resources to pay for the kind of care my mother was receiving, but she qualified for Medicaid. I was able to get her into the nursing home with my mother, where I paid for her care until we could find a Medicaid bed for her.

I knew the care she was getting as a Medicaid beneficiary was substandard, but there was no other way to do it. Aunt Maggie died 4 years later, in 1983.

Our story is not unique. It is one that can be told over and over again—with all kinds of variations—by millions of American families.

As our population ages, the problem will only get worse. Probably 14 million people by the middle of the next century will have

Alzheimer's. Half of us in this hearing room today if we live to be 85 will get Alzheimer's.

For those of us who have reached middle age, the molecular mischief that causes Alzheimer's has probably begun. There is nothing we can do about it until science tracks down more clues to the disease. But there is something we can do now to make sure that the people we love, our spouses, our children, our siblings, our friends do not have to take on the entire burden and cost of care when we can no longer care for ourselves.

Families approach their care-giving responsibilities with unbelievable strength and love. They do not want government to take over for them. They do not want welfare. They do want and desperately need a fair continuum of help.

That is why the Alzheimer's Association supports a Federal long-term care social insurance program that will provide universal, comprehensive protection to Americans of all ages and incomes. That system should be financed progressively and equitably across all generations.

Coverage must be provided for services needed across the continuum of care, in the home and community as well as in institutions. And it must be provided in a manner that preserves the independence and dignity of the individual and supports the family as caregiver and decisionmaker.

The Association welcomed the report and recommendations of the Pepper Commission as an important step toward our long-term care objectives.

The Commission has defined the scope and cost of the problem and has offered a modest package of publicly funded benefits that build on a social insurance model. For the first time, government would provide real help to Alzheimer's patients and families.

The bill you have introduced, Mr. Chairman, H.R. 651, the Medi-Plan Long-Term Care Act of 1991, would move us even further toward a comprehensive social insurance approach to long-term care. We applaud your efforts.

You have asked the association to comment specifically on two provisions in the Medicare Catastrophic Benefit Act that would have expanded home care and skilled nursing facility benefits. Congress repealed both these benefits in 1989. Unfortunately, neither of these benefits would help most Alzheimer's patients. They cannot qualify because there is no medical treatment for Alzheimer's disease.

In effect, these benefits are extended care for persons who need skilled care. The changes you are considering are useful improvements for those who qualify, but they will not provide much help with the long-term care needs of families dealing with Alzheimer's disease.

We believe there is an affordable first step toward long-term care you can take now. That is respite care.

I want to emphasize we are not suggesting that you restore the medicare catastrophic benefit. That would not help Alzheimer's patients and caregivers.

We are working to refine a proposal for your consideration that will be both meaningful and affordable. We think this is an essential first step toward long-term care, to support and sustain the in-

formal care-giving system that is out there now and that provides the bulk of long-term care in this country. We will be anxious to work with you toward its enactment.

I think it is important to emphasize that more than 70 percent of the care being provided in this country for Alzheimer's families is currently being provided at home by informal, unpaid family caregivers. We don't want to reinvent the wheel. We want to acknowledge and recognize that system, build on it and support it so that people like myself do not have to put their family members in institutions prematurely.

In closing, let me commend you again, Mr. Chairman, for your dynamic leadership on the issue of long-term care and for your insistence that it be kept on the national agenda. We appreciate the opportunity to participate in this hearing.

The association, our chapters and our millions of families throughout the country are absolutely committed to working with you to develop a system that makes sense for patients, for caregivers and for the nation.

Thank you.

[The prepared statement follows:]

DEVELOPING A NATIONAL LONG TERM CARE STRATEGY
FOR THE CHRONICALLY ILL AND THEIR FAMILIES

Statement by Bill Keane
CoChair, Public Policy Committee
The Alzheimer's Association

Chairman Stark and Members of the Subcommittee, I am pleased to appear before you today to discuss one of the most urgent human problems facing this country today -- the problem of providing care for millions of Americans who face long term chronic illnesses like Alzheimer's disease.

Long term care is already a crisis for millions of American families. Within our lifetimes, it will overwhelm our health care system if we do not address it responsibly now.

I commend you, Mr. Chairman, for holding this hearing today, and for your continuing efforts to keep long term care on the national agenda. We wholeheartedly support you.

I appear before you today as CoChair of the Public Policy Committee of the Alzheimer's Association -- the national voluntary health agency that speaks for the 4 million Americans and their families who today confront the awful tragedy of Alzheimer's disease, as well as those who suffer from related disorders. We work through over 200 chapters, 1600 support groups, and 30,000 volunteers in every part of the country.

Long term care, along with research, is the top public policy priority for the Association. We are a lead organization, along with AARP and Families, USA, in the Long Term Care Campaign, an effort of more than 140 national organizations and 27 state and local coalitions to build the support necessary to enact comprehensive long term care legislation.

I also appear before you as a caregiver. My family has been through the experience of Alzheimer's disease, not once but twice over the last fifteen years.

Alzheimer's Disease -- the Quintessential Long Term Care Problem

Alzheimer's is a devastating degenerative disease. It takes a person you know and love, and robs her of everything -- memory, judgement, personality, dignity -- that made her a unique human being. The disease is irreversible, largely untreatable, and inevitably fatal.

I would like to take a moment to tell my family's story, not because it is special, but because it is all too typical of the long term care crisis in this country.

In 1975, I was working in Upper New York State. My parents were retired and living in suburban Philadelphia. I came home to visit, and found things in chaos. My mother, who had managed our household with care and efficiency for more than 40 years, could not figure out how to do the laundry or fix even a simple meal. Dad was trying to cover up for her, denying that anything was wrong. They finally agreed to see a doctor -- and after extensive testing, the diagnosis came back. My mother had Alzheimer's disease.

Mother deteriorated rapidly. Doctors told us she probably had only a year or two to live. We tried to keep her at home, but that became impossible. Dad simply could not cope. I moved back home, but I had to work during the day. And there were no

services available to help us in the county where we lived -- no home care, no day care, nothing that would give us even a short break from the constant demands of caring for Mother.

We had no choice but to move her to a nursing home, where she lived -- despite all the doctors predictions to the contrary -- for almost 10 years. We paid the nursing home more than a quarter of a million dollars -- everything my parents had saved for their retirement years.

In a way, I suppose, we were lucky -- Dad had been a federal employee for 25 years. He had a good pension, and throughout their working years, he and mother had put away money "to see the world". Things didn't work out the way they had planned, but at least there was money to pay for decent care. Not many people have enough money to do that today.

Alzheimer's killed both of my parents. Dad actually died two years before my mother, worn out -- physically, emotionally, and financially. On one of my last visits to him in the hospital, he told me his life had come to an end eight years earlier, when Alzheimer's disease stole the woman he loved.

Sadly, that is not the whole story. In 1978, while we were coping with my mother's care, her older sister was diagnosed with Alzheimer's. Aunt Maggie had never married, and I was responsible for arranging her affairs. She had no resources to pay for the kind of care my mother was receiving, but she qualified for Medicaid. I was able to get her into the nursing home with my mother, where I paid for her care until we could find a Medicaid bed for her. I knew the care she was getting as a Medicaid beneficiary was substandard, but there was no other way to do it. Aunt Maggie died four years later, in 1983.

Our story is not unique. It is one that can be told over and over again -- with all kinds of variations -- by millions of American families.

That is why you cannot move long term care to the back burner. As our population ages, the problem will only get worse. Evidence now shows that 10% of all Americans over age 65 -- and nearly half of those over age 85 -- have probable Alzheimer's. That translates to 4 million people today, and nearly 14 million by the middle of the next century.

Half of us in this hearing room today, if we live to be 85, will get Alzheimer's disease. For those of us who have reached middle age, the researchers tell us the "molecular mischief" that causes Alzheimer's has probably already begun. There is nothing we can do about it -- until science tracks down more clues to the disease. But there is something we can do now, to make sure that the people we love -- our spouses, our children, our siblings, our friends -- do not have to take on the whole burden and cost of care when we can no longer care for ourselves.

If you understand what Alzheimer's disease does to a family, you know you do not want to leave your loved ones to deal with it on their own. Alzheimer's gradually takes the very essence of the person and leaves behind an empty shell -- one who often remains physically healthy well into the course of the disease. That in itself is hard enough to bear. But with the loss of memory and judgement and self awareness comes a host of practical problems. Some of them are difficult to manage physically - dressing an uncooperative adult is even harder than trying to get a shirt on a restless toddler. But those are the relatively easy ones. It is the constant agitation, the incessant pacing, wandering, sleeplessness, hallucinations and suspicions, the dangerous behavior that means the caregiver can never get away. The final indignity incontinence, is often the crowning blow.

Families approach their caregiving responsibilities with unbelievable strength and love. They do not want government to take over for them. But they do want -- and desperately need -- help.

Developing a National Long Term Care System

The Alzheimer's Association supports a federal long term care social insurance program that will provide universal, comprehensive protection to Americans of all ages and income. That system should be financed progressively and equitably across all generations. Coverage must be provided for services needed across the continuum of care, in the home and community as well as in institutions. And it must be provided in a manner that preserves the independence and dignity of the individual and supports the family as caregiver and decision-maker.

The Association welcomed the report and recommendations of the Pepper Commission as an important step toward our long term care objectives. The Commission has defined the scope and cost of the problem and has offered a modest package of publicly funded benefits that build on a social insurance model. Enactment of its recommendations would mean that, for the first time, government would provide real help to Alzheimer patients and families.

The bill you have introduced, Mr. Chairman, H.R. 651, the MediPlan Long Term Care Act of 1991, would move us even further toward a comprehensive social insurance approach to long term care.

Home and Community Care. Most Alzheimer patients -- at least 70 to 80% -- live in the community where informal caregivers provide most of the assistance and supervision they need. The majority of these caregivers are spouses -- some are physically frail and confused themselves. Today, the average age of caregivers of the frail elderly is nearly 60. As the population needing care grows older, so will the persons providing care.

Among adult children who have primary responsibility for care, at least one-third are also trying to work, at least part-time. Many divide their time, their money, and their emotions between frail parents and their own children.

Perhaps the most alarming aspect of this informal care system is that it leaves as many as 20% of Alzheimer patients living alone.

To gain some insight to these national statistics, last year we conducted an informal survey of Association volunteers. All of them were or had been caregivers. Nearly half had provided care at home for at least 7 years; one-quarter for 10 years or more.

Caring for an Alzheimer patient at home is expensive. For those who hire outside help, the cost is prohibitive. In our survey, one caregiver reported caring for his wife at home for 11 years and, by the end, paying $30,000 a year for home care. Another paid over $80,000 during 8 years of caregiving at home.

Even if the family caregiver is not working and provides full-time care himself or herself, a family can easily spend $5000 to $6000 a year for care supplies and occasional help. Just the cost of diapers for an incontinent adult can amount to $60 a week.

None of these costs is covered by Medicare, because they are not medical services, they are not medical supplies.

Medicaid may provide some help, in states that operate a 2176 waiver program or choose to take advantage of the new Home and Community Care options Congress enacted last year. But these services are limited to persons with the very lowest income and are threatened by the fiscal problems states now face.

It is little wonder that, when asked, "If government has to choose between providing home care or nursing home care as the first step in long term care services, which would you prefer?", our volunteers, by a two-to-one margin, said you should start with home care.

Nursing Home Coverage. Nursing home coverage is critically important too. The reality is that large numbers of persons with Alzheimer's disease or other cognitive impairments do spend the last years of their lives in nursing homes -- where they make up at least half of the total population of nursing home residents.

For a resident with Alzheimer's disease, a stay in a nursing home can go on for a long time, long enough to exhaust all of the resources most families have. Our survey of volunteers found that nearly 85% of Alzheimer patients who were placed in nursing homes stayed for more than a year. Sixty percent had been there more than four years -- some, like my mother, for 10 years or more.

The typical cost of a nursing home for our families ranges from $25,000 to $40,000 a year. Some of the families in our survey had already spent over $500,000 on nursing home care. They get no help at all now, until they have spent down to the eligibility limits that qualify them for Medicaid.

That is why long-term coverage of nursing home stays is so important for families dealing with a disease like Alzheimer's. Coverage for the first three months of a stay, as recommended by the Pepper Commission, may help Alzheimer patients get in the door. But they will need the type of help provided by H.R. 651 to meet the real costs of nursing home care.

Eligibility. Your bill, Mr. Chairman, like the Pepper Commission recommendations, recognizes that disability caused by a cognitive impairment like Alzheimer's disease is different from a physical disability. While Alzheimer patients may remain physically capable of performing certain activities of daily living well into the disease, they have forgotten how to do them and must have someone there to remind them, cue them, and supervise them. Many cannot safely be left alone because their judgement is so impaired -- they will leave a cigarette burning on the bed or the gas burners on in the kitchen. They will wander off with no idea of where or who they are.

These needs must be specifically recognized in definitions of persons eligible for long term care services. H.R. 651 does this well. We commend you.

Incremental Improvements in Medicare Benefits

You have asked the Association to comment specifically on two provisions in the Medicare Catastrophic Benefits Act that would have expanded home health and skilled nursing facility benefits. Congress repealed both of these benefits in 1989.

Unfortunately, neither of these benefits would help most Alzheimer patients. They cannot qualify because there is no medical treatment for Alzheimer's disease. A few patients may be eligible for Medicare benefits, either because they have an intercurrent illness that does qualify them for home health care, or because the disease has progressed to a stage where they require skilled nursing care. For example, a family caregiver

from Maryland testified recently about her grandmother, who qualifies for Medicare home health care benefits, not because she has Alzheimer's but because she also has pernicious anemia.

Obviously, those patients who do qualify for home health care because of an intercurrent illness will benefit from the extension of those benefits to 38 days. But this will not be more than a handful of Alzheimer patients.

Elimination of the requirement for a 3-day hospital stay prior to admission to a skilled nursing facility may be even more important for Alzheimer patients. Transfer to a nursing facility is a difficult, often traumatic experience for most older persons. For an Alzheimer patient, it is doubly so. Any change in environment subjects the confused Alzheimer patient to enormous stress and agitation. Often, it takes weeks to calm the person to the new environment. If a determination is made that an Alzheimer patient needs skilled nursing care which is reimbursable under Medicare, there is no reason to subject that patient, the family, or the Medicare system to the additional expense and the trauma of a hospital stay unless that hospital stay is medically indicated.

Even with such a change, the Medicare nursing home benefit will not make a notable dent in the need for long term care, because most patients will not qualify, and for those who do, their need for care will last far longer than the benefit Medicare allows.

Respite Care -- Supporting Family Caregivers as a First Step toward Long Term Care

We note that you have not included in this hearing discussion of the Medicare Respite Benefit that was part of the Catastrophic legislation. As you know, the Association had raised a number of concerns about that benefit, which would not have been available to most, if any, Alzheimer patients and caregivers. We appreciate your consideration of our concerns.

The Association has made respite care a top priority for this Congress. We are working to refine a proposal for your consideration that will be both meaningful and affordable. We think this is an essential first step toward long term care, to support and sustain the informal caregiving system that is out there now and that provides the bulk of long term care in this country. We will be anxious to work with you toward its enactment.

In closing, let me commend you again, Mr.Chairman, for your leadership on the issue of long term care and for your insistence that it be kept on the national agenda. We appreciate the opportunity to participate in this hearing. The Association, our chapters, and our families throughout the country are absolutely committed to working with you to develop a system that makes sense for patients, for caregivers, and for the nation.

Thank you. I will be happy to respond to your questions.

Chairman STARK. Thank you all.

I guess this is the first time we have heard from you or your organizations since the Fiscal Year 1992 budget.

Do your organizations have a position on the President's proposal to income base the part B premium?

Mr. RICHTMAN. Mr. Chairman, the national committee has circulated a letter opposing the Medicare cuts that are in the President's budget. We have done so in cooperation with the American Hospital Association, and we have brought together 17 consumer and provider groups that have taken the position that further cuts beyond the huge cuts which many of us did finally sign off on at the end of the last Congress are going too far.

Chairman STARK. What about the income relating part?

Mr. RICHTMAN. We oppose the whole package.

Chairman STARK. Good.

Dr. Dixon.

Ms. DIXON. AARP feels that we should not have income-related part B financing. We feel the financing should be very broad.

Chairman STARK. Premiums or financing? I guess I meant the premium specifically. Financing, I think of as taxes and some other stuff.

Ms. DIXON. We feel that since Medicare is in for $43 billion in cuts within the next 5 years, that that is going far enough and that we should not increase the premium.

Mr. KEANE. Likewise, we have not supported an income or means-tested approach toward the solution of this problem.

Chairman STARK. OK.

The benefits in H.R. 1200, as all of you know, are incremental. It is a little bit of what I suppose most people would like and far from everything that we all want.

Do each of you agree that we should go ahead with incremental changes in a climate which is obviously not ready for a broad reform at this point or broad changes? And if you agree that there ought to be incremental changes, are there any incremental changes that you would far prefer to those that are in H.R. 1200?

Ms. DIXON. I am sorry, Mr. Stark; I didn't understand your question?

Chairman STARK. Well, some people feel we ought to go ahead and make small changes like extending the skilled nursing benefits and a few things like that as we can pay for them. Some people don't. Some people say don't tinker with it, wait and get it all done at once mostly because we get bothered around here because we don't have something to do, we have decided to make small changes in Medicare.

If you agree that we should make incremental changes rather than waiting around for the revolution, are the incremental changes that we have proposed acceptable to you or do you think there are some changes that much more important, small ones?

Ms. DIXON. Well, AARP feels that we have waited long enough, and that the longer we wait the greater the cost will be. We feel that we should go ahead and put into effect some small steps because we cannot do the whole thing at one time.

We feel that we should look at home health care, we should look at institutional care, we should look at care in situations outside of the home.

We also are in favor of a respite care. We feel that these are very important and that they should be instituted as soon as possible.

Chairman STARK. OK.

Max?

Mr. RICHTMAN. Mr. Chairman, the national committee believes that we really can't afford to wait for the revolution. But at the same time——

Chairman STARK. You guys are pretty good at starting them. Maybe you could get one going.

Mr. RICHTMAN. Mr. Chairman, I think at the same time we can't afford to wait for the revolution, we can continue working towards it with the proposal that you have advanced. I think that is an important step.

It doesn't preclude working towards the revolution. The revolution was your term, you know.

Chairman STARK. Mr. Keane?

Mr. KEANE. I don't think you would have held this hearing, Mr. Chairman, if you felt the mood of the country was not there. I think the challenging role facing us is to educate that mood.

Certainly, if somebody said that to go to Saudi Arabia just didn't fit in this year's budget there would have been some response to that.

I think my mother was one who was great at teaching me the fact that where there is a will and persistence, there is always a way.

We are seeing, as the numbers of families needing long-term care dramatically increase, that there is increasingly a mood to take a more bold, comprehensive, long-range approach towards this and to begin with responsible steps.

We do not oppose any of your proposals, in terms of the Medicare changes, but most of our constituents would really not benefit from them, since they really assist those who need skilled services as currently defined by Medicare. That is why we are proposing a look at the issue of respite care.

Chairman STARK. You are right about your reference to the war. We have had several wars that have been declared recently, on drugs, education, infant mortality, long-term care. The way I read it, the President is batting about less than .200. He won the easy one. He is getting our allies to pay for that.

The tough one is how to figure out how to get his constituents, the American people, to pay for these other wars. I think those are wars being ignored at the country's peril.

The pollsters tell us that 75 percent of the American people want some kind of national health scheme, insurance, whatever. Unfortunately, they also tell us that it is not an issue of highest urgency.

Therefore, politicians, whether it is the President or myself, won't be blamed if they don't pass it. But they will be applauded if they do.

So I am going to have to challenge you three and your organizations. It is up to you, because it is obvious the President isn't going to do it. I challenge you and your organizations to raise the level of

urgency and raise the level of tension in this country among your constituents almost to the point of contention. And then, perhaps, this Administration will decide that the next war that we fight, the next batch of yellow ribbons ought to come out on the trees for long-term care or health care for every American.

But the one, the organization that gets that urgency going is going to be the one whose agenda will get passed first. We are counting on you.

Thank you for helping us again today with your testimony.

We look forward to creating those itches out there among the public, and we will try to help you scratch them.

Thanks a lot.

Our third panel represents those who would get paid if we could pass some legislation, the providers.

We are pleased to welcome Mr. John Selstad, representing the American Association of Homes for the Aging. He is the vice president of the Ebenezer Society of Aging in Minneapolis, Minn., a society which is a multilevel older adult service organization which provides housing, transportation and all levels of nursing home care.

Dr. Paul Willging, is the executive vice president of the American Health Care Association. And Fran Bäby, who is president of the National Association for Home Care. She comes from First Choice Health and Personal Service, Inc., Columbus, Ohio.

I have been informed that I have a phone call. I am going to ask you to withhold for a moment or two and I will return.

The subcommittee will recess for just a minute.

[Recess.]

Chairman STARK. Please proceed.

I want to welcome the panel to the committee and ask you if you would like to proceed to summarize for me or outline your prepared testimony in any manner you are comfortable.

Mr. Selstad.

STATEMENT OF JOHN SELSTAD, VICE PRESIDENT, EBENEZER SOCIETY FOR AGING, MINNEAPOLIS, MN, ON BEHALF OF THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING

Mr. SELSTAD. Thank you, Mr. Chairman.

Ebenezer Society is a member of the American Association of Homes for the Aging. Therefore, I am speaking today on behalf of that association.

Our written testimony does support five aspects of H.R. 651. Those being the elimination of the three day prior hospitalization requirement, the expansion of home health, the expansion of the SNF benefit, including the addition of adult day care, the prepayment financing and the use of case management strategies.

But today I would like to expand on and focus on two issues that are in H.R. 1200, that being the three day hospitalization requirement and the home health expansion. The context for my remarks is that Ebenezer Society is a cosponsor of a social HMO. Social HMOs already incorporate all five of these aspects that AAHA supports. Our social HMO, Seniors Plus, in Minneapolis, is a joint ven-

ture between Ebenezer Society and Group Health Incorporated, a 300,000 member staff model HMO.

The data base that I shared in the written testimony consists of 3,600 Social HMO members and 17,000 Medicare HMO enrollees. The Social HMO, as you might remember, is a high option Medicare HMO, but also it adds special benefits that in effect gives us coverage for home and community based long-term care.

Mr. Chairman, we do all of this coverage within the current funding streams, Medicare, Medicaid and private premiums.

When we looked at our data for these 20,000 covered lives in 1989 and combined the issue of the three day prior hospitalization requirement, we found that in three out of four cases when we made admissions to a SNF, the patient did have three or more hospital days.

However, one time out of four they did not. Four percent of the time they had either one or two days in the hospital, and fully one out of five times they were direct admissions under Medicare criteria into the SNF.

I would like to say that the diagnoses that presented those admissions ranged broadly. What seemed to tie them together was they would tend to be individual enrollees in our plan that had multiple problems. They were often there for the observation and monitoring by a professional nurse, or for the change in a prescription drug regimen by a physician.

These situations oftentimes corresponded to crises in the family care giver support structure. As we look at our experience, while they meet SNF criteria, it is complex and involves not only health issues, but long-term care issues such as care-giver situations.

When we looked at the issue of expanding the home health coverage for daily home health from 21 to 38 days, the Seniors Plus program only infrequently needs to go beyond 21 days. However, our benefit does allow us to continue care beyond 21 days and when we do they are heavy care, complex situations. Frankly, when this type of situation arises, if continued care were to be denied, it would be very hard to explain to the beneficiary or their family why they were covered one day but not on the next day.

I think this understandability, and increased appropriateness in the design of the social HMO benefits as opposed to straight Medicare is a factor that supports the reforms proposed in H.R. 1200.

In closing, I would just like to thank Congress for the support that you have given the social HMO demonstration in the past. Without your assistance, our demonstration would not have existed for these last 6 years and be continuing through 1995.

And I would hope that the experience of this clinical environment would allow the committee to test some of the results of the proposals that you have put before Congress.

Thank you, sir.

[The prepared statement follows:]

STATEMENT OF JOHN SELSTAD ON BEHALF OF
THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING

Chairman Stark and members of the Health Subcommittee, I am John Selstad, Vice-President of the Ebenezer Society for Aging located in Minneapolis, Minnesota. The Ebenezer Society, an affiliate of Parkside Senior Services, is a multi-level older adult service organization that provides housing, transportation, community services and all levels of nursing home care. Ebenezer also serves as the site for two Federal Medicare demonstration projects, the Social Health Maintenance Organization Demonstration and the Alzheimer's Demonstration program. I am here today to testify on behalf of the American Association of Homes for the Aging (AAHA).

AAHA is a national nonprofit organization whose membership embodies the entire continuum of long-term care services. AAHA represents over 3,500 nonprofit providers of health, housing and community-based services, including continuing care retirement communities (CCRCs), adult day care providers and home health care agencies. Through direct delivery of services in their facilities, AAHA members serve over 600,000 elderly individuals annually, while at the same time striving to meet the needs of an additional 1,000,000 older people through various outreach programs. Religious organizations sponsor 75% of AAHA members, with the remaining members sponsored by private foundations, fraternal organizations, government agencies, unions and community groups committed to providing quality services for their residents and for elderly persons in the community-at-large.

AAHA appreciates the opportunity to testify before this Subcommittee on the pressing and critical issue of long-term care coverage and financing. Adequate access to long-term care services, and financial protection against the potentially catastrophic costs of these services, represent the single greatest risk to the elderly and their families. The need for flexibility in the delivery of long-term care services and adequate payment for these services are among the greatest concerns facing providers of aging-related services. Mr. Chairman, we commend you for the introduction of several amendments which will expand access to long-term care services for millions of Medicare beneficiaries through the elimination of the three day prior hospitalization requirement and a modest expansion of home health benefits. We also commend you for the introduction H.R. 561, The Mediplan Long-Term Care Act of 1991, a bill which establishes one comprehensive approach to reforming the long-term care financing and delivery system.

We are here today to offer our support of several aspects of these legislative proposals. Specifically, we support: (1) the elimination of the 3 day prior hospitalization requirement for eligibility for skilled nursing services; (2) expansion of coverage for nursing facility services to 180 days; (3) expansion of the home care benefit from 21 to 38 days and the inclusion of adult day care as a covered service; (4) the use of disability measures in the determination of benefit eligibility; and (5) the use of care-management strategies. We also support the use of case-mix indicators as a measure of the intensity of resources required for patient care as long as these measures are adequately linked to appropriate payment levels. Given the comprehensive nature of the changes embodied in H.R. 651, we will be submitting an addendum to our testimony to address additional aspects of this legislation.

THE NEED FOR LONG-TERM CARE COVERAGE AND FINANCING

The need to increase access to and financing for long-term care services are two of the most difficult issues facing this Subcommittee, Congress and the Administration. The significance of these issues is related to the demographics and income levels of the older population. The demographics of aging portray the reality of the need for long-term care coverage, now and in the future. Both the projected growth in aggregate numbers and the increasing proportion of the elderly to the general population are startling. The U.S. Bureau of the Census has reported that the 65 and over population will expand from 12.7 percent of the population in 1990 to 21.8 percent in 2050. Moreover, the fastest growing segment of this population — those 85 and over — will expand from 10 percent of all those over 65 to 24 percent of this population.

The dramatic increase in the older population has significant ramifications for the long-term care financing and delivery system. According to the 1987 HHS National Medical Expenditure Survey (NMES), about 7.1 million individuals over the age of 65 have long-term care needs. About 1.5 million are confined to nursing homes and about 5.6 are disabled in the community. These statistics will increase in proportion to the growth of the older population. Furthermore, the over 85 have the highest prevalence of disability requiring long-term care services and will create the greatest demand for nursing home and community-based services. While less than one in ten individuals under the age of 75 is disabled, more than 50 percent of those over 85 are disabled in a nursing home or in the community.

The need for long-term care services for those with chronic illness or disabilities is the greatest catastrophic risk faced by the elderly and their families. The lifetime risk of requiring nursing home admission at age 65 is about 40%. And while the average length of stay in a nursing home for those who are admitted is estimated at 1.6 years, it is also estimated that as many as 10% of nursing home residents stay 5 years or longer. With average annual nursing home costs ranging from $25,000 - $36,000, depending on geographic location, the lifetime costs of nursing home care can be catastrophic. Since Medicare covers less than 3% of total annual nursing home expenditures, and only 5% of the over-65 have private insurance that covers such expenses, long nursing home stays spell impoverishment for many who experience average stays and for most who have long nursing home stays. Currently, the United State has only one federal policy for handling the long-term care needs of its elderly and disabled citizens, and that is Medicaid. Due to the absence of public insurance and the dearth of coverage under the private long-term care policies that are available, almost half of all nursing home expenditures are financed out of pocket and less than 2% are paid for by private insurance. The remaining expenditures are financed by Medicaid — after individuals have exhausted their assets and income to become eligible for these benefits.

Although the number of disabled individuals requiring community-based services is much greater than the number requiring nursing home care, public and private-sector insurance coverage of home and community-based services is also sorely lacking. And while the cost of home care services for the severely disabled can cost upwards of $15,000 annually, only about 25% of individuals who are disabled in the community use paid formal support services. Only about 3% of total Medicare expenditures are used for home care services. Eligibility for such services is extremely restricted and limited to the severely disabled. Private insurance coverage of home care services has only recently become available and pays for an even smaller percentage of home care than nursing home services. Furthermore, in the past, only states that were granted Medicaid waivers (2176 waiver programs) used significant Medicaid funds to pay for home care services. And while the 1990 budget agreement included close to $600 million in funding for a new home and community-based services program, the requirements for participation in this program and low payment rates create disincentives for provider participation.

Due to the absence of adequate insurance coverage or public assistance for community-based services, the majority of this type of care is provided by families and informal care givers. Between 80 and 90 percent of the disabled elderly who remain in their own homes receive assistance from relatives and friends. American families expend considerable time and effort in taking care of elderly relatives, with one study estimating that families provide more than 27 million unpaid days of informal care each week. Furthermore, spouses and children providing informal care often incur substantial physical and emotional strains in caring for their elderly relatives. It is not uncommon for an older husband or wife to become disabled by the physical burden of providing continuous care for his or her spouse. Yet existing federal health policy does little to support these families. Efforts to reform our nation's long-term care system must recognize and nurture the important contribution made by families. Such efforts would not only be humane, but would also contribute to the economic efficiency of a national long-term care policy. AAHA is gratified that the community-based services provisions in H.R. 651 proposed by the Chairman of this Subcommittee do recognize these human and economic contributions.

The lack of public and private insurance coverage for long-term care services spells financial catastrophe for many elderly. Furthermore, due to the inverse relationship of age and income, those who are the oldest have the greatest needs and are least likely to be able to afford to purchase long-term care insurance. About half of all long-term care expenses are incurred by those over 85. And while only 28% of those aged 65-74 have incomes below $10,000, 62 percent of the 85-plus population fall into this income category.

Clearly the magnitude of the long-term care financing dilemma is staggering. But the response from the Congress and the Administration must not be to dismiss solutions to the problems of coverage and financing for long-term care services as beyond our reach — an action that has been taken too many times in the past. Rather, these facts demand that action be taken now to address the needs of the current elderly and to plan and prepare for the future. Mr. Stark's legislation offers one approach to meet this demand. Below are specific comments on various aspects of legislation being considered by this Subcommittee.

ELIMINATION OF THE THREE DAY PRIOR HOSPITALIZATION REQUIREMENT

The Medicare Catastrophic Coverage Act (MCCA) of 1988 included three provisions under consideration by this Subcommittee which increased access to long-term care benefits. These included elimination of the three day prior hospitalization requirement as a condition of eligibility for nursing facility benefits; a modest expansion of home health care benefits and clarification of the definition of eligibility and coverage for home health care benefits; and expansion of nursing facility benefits. Each of these improvements to the Medicare program were retracted when the MCCA was repealed in 1989.

AAHA has long supported the elimination of the three day prior hospitalization requirement and commends Mr. Stark for reintroducing this legislation. AAHA contends that this requirement poses a barrier to older individuals who, for a variety of reasons, require nursing facility services but, under Medicare rules, can only access these services by first entering a hospital. We also believe that there are more objective and reliable ways to measure nursing home need than prior hospitalization.

One such proxy includes needs assessment instruments which measure functional and cognitive impairments, as provided for in H.R. 561. Furthermore, data from the Federal Social Health Maintenance Organization (SHMO) Demonstration illustrates that the elimination of the prior hospitalization requirement will not lead to higher costs for Medicare, as feared by many policy makers. To the contrary, the SHMO data reveal that the elimination of this requirement can actually result in savings of total system costs.

AAHA recently analyzed data from Seniors Plus and Group Health Seniors, two organizations affiliated with the Ebenezer Society. Seniors Plus is one of four national SHMO sites and serves 3,600 older adults. Group Health Seniors, a part of the Group Health HMO serving 300,000 individuals of all ages, provides services to 17,000 seniors under a Medicare Risk Contract. The SHMO Demonstration is a national project designed to increase the elderly's access to chronic care services at no extra cost by integrating the financing and delivery of acute and long-term care services into a single system. The concept of a cost-neutral expansion of chronic care services was based on savings achieved through a variety of care-management strategies employed by the SHMO. SHMOs are financed on a prepaid, capitated, at-risk basis and are financed through three revenue sources: Medicare, Medicaid and private premiums. The SHMO sites provide members a full range of acute medical and ancillary services as well as $6,000 to $12,000 of chronic care services annually. Chronic care services include homemaker, personal care aide, respite, adult day health care and transportation.

The SHMOs operate under Medicare waivers that do not require the use of standard Medicare criteria in determining benefit eligibility. As a result of these waivers, the data regarding SNF admissions allows us to analyze practice patterns driven by clinical need — not by Medicare eligibility and payment rules. Data regarding Medicare skilled nursing facility admissions from members of Seniors Plus and Group Health Seniors reveal

three observations supporting the contention that the elimination of the prior hospitalization requirement would not increase Medicare costs. These data are based on an enrollment population of approximately 20,000 seniors. During a one-year period, this population had 619 admissions to skilled nursing facilities. First, of those admitted to skilled nursing facilities, 75 percent had a three day prior hospitalization prior to admission. This demonstrates that, although this population was not subject to standard Medicare rules, the majority of nursing home entrants nevertheless had a prior hospital stay of at least three days. This data suggests that providers who were not subject to traditional Medicare rules did not attempt to "game" the system by direct admission to a skilled nursing facility.

Second, 4% of the population admitted to the skilled nursing facility were admitted after a one- or two-day hospital stay; these admissions were equally divided among one- and two-day stays (i.e., 2% had one-day stays and 2% had two-day stays). These data suggest that providers were attempting to channel patients to the most appropriate setting based on their needs and that this channeling resulted in shorter hospital stays and Medicare savings. Had the members of Seniors Plus and Group Health Seniors been subject to Medicare rules, each patient would have been required to stay in the hospital one or two days longer to become eligible for skilled nursing services.

Third, 21% of the population represents direct admissions to a skilled nursing facility with no hospital days prior to 30 days of SNF admission. The savings achieved for this population through the elimination of the three day prior hospitalization requirement could be used either to expand the amount of services provided to the same number of individuals or to expand the number of individuals served without increasing total system costs.

Data from the SHMO projects indicate that, through careful care-management strategies and provider risk-sharing, long-term care services can be provided cost-effectively. Furthermore, clinical practice patterns and service expenditures reveal that a wide range of clinical diagnoses from cancer and dementia to fractures and chemical dependencies often can be treated effectively when substituting lower-cost services for traditional services, such as substituting skilled nursing for hospital services or home-care for skilled nursing services, without jeopardizing the quality of their care. These cost savings can be used to serve a broader segment of the population for the same dollars. Since the elderly prefer to receive care at home, this suggests that the elderly's quality of life can be improved as well.

The ability to reduce costs by service substitution through access to a full range of long-term care services also has been demonstrated in studies of continuing care retirement communities (CCRCs). A 1987 study conducted by Brandeis University revealed that while the average length of stay in a nursing home for individuals admitted from the community-at-large was 455 days, the average length of stay for CCRC nursing home residents was 179 days. This study indicated that, in some cases, residents were able to be diverted from hospitals to nursing homes based on the availability of skilled nursing facility services provided by the CCRC.

The experience discussed above is based on data from one of only the four national SHMO demonstration sites. I would respectfully suggest that the Subcommittee request additional data from the SHMO Consortium at Brandeis which incorporates the experience of all four sites. I am confident that these data would further attest to the cost-effectiveness of eliminating the three-day prior hospitalization requirement.

Finally, AAHA believes that the elimination of the three day-prior hospitalization requirement could save Medicare dollars by reducing the costs associated with unnecessary hospital days. Although moratoria on the construction of nursing home beds have been lifted in many states, access to nursing facility services is still restricted in many cases by bed shortages. In cases where a nursing facility bed is not available to a hospital patient at the time such patient is ready for discharge to a nursing facility, some hospitals can maintain the patient in a "swing bed" designated for use as an acute care or long-term care bed. Payments for these extra days are not included in the DRG rate, but paid separately. Since the average daily cost of hospital care far exceeds the daily rate for nursing home care, elimination of the three-day prior hospitalization requirement could save Medicare dollars incurred by patients admitted to the hospital for purposes of eligibility for nursing home care who incur expenses outside the DRG rate while awaiting nursing home admission.

AAHA also supports the provisions in H.R. 561 which would expand nursing facility benefits from 100 to 180 days. AAHA was supportive of the provision in MCCA which would have expanded skilled nursing facility benefits to 150 days. While this expansion alone does not fully address the need for long-term care coverage, it would be an important step in filling gaps in existing Medicare coverage. Furthermore, during the short period of time that MCCA provisions were operative, AAHA members noted improved access to skilled nursing services by their residents. As a result, many elderly were able to delay exhausting their resources on nursing home costs. This expansion of nursing facility coverage is one of the most significant aspects of your bill and we urge that it be enacted and effective immediately.

EXPANSION OF COMMUNITY-BASED SERVICES

AAHA supports amendments to Medicare to expand coverage of home health care services from the current 21 day limit to 38 days and to clarify the definitions regarding coverage of and eligibility for "intermittent care." These provisions were included as part of the Medicare Catastrophic Coverage Act (MCCA) and subsequently lost when MCCA was repealed. Since reinstatement of these provisions are critical to assuring the elderly appropriate access to home care services, we commend the Chairman and his colleagues for introducing Medicare amendments this year which redress two critical problems.

First, clarification of "intermittent care" language would correct the current inconsistency in coverage and payments resulting from different definitions of daily care for purposes of eligibility for home care and coverage for home care. Second, clarification would provide a guaranteed number of days of daily care for individuals that require daily care in a non-institutional environment, but for whom the exact duration of care cannot be determined in advance.

Clarification of the "intermittent care" language is critical since it determines the nature of services provided and the frequency of home care services provided to millions of elderly and disabled individuals. Because "intermittent care" was not specifically defined when Medicare home care benefits first were enacted, access to these benefits often is denied due to inconsistencies in interpretation of "intermittent care" by the Health Care Financing Administration (HCFA) and its Fiscal Intermediaries (FIs). The definition of daily care for purposes of coverage, once eligibility has been established, was clarified under a law suit filed against the Department of Health and Human Services in 1987. Since the repeal of MCCA, however, there are two different definitions for daily care — one for coverage and one for eligibility. For purposes of eligibility for home care services, daily care is defined as five to seven days per week. For purposes of coverage, the suit brought against HHS defined daily care as seven days per week. Amendments are critically needed to correct the inconsistency in definitions of coverage and eligibility and to ensure that beneficiaries are deemed eligible for services covered by Medicare.

AAHA recommends two additional amendments to the Medicare home care benefit. First, we recommend the reinstatement of the provision under MCCA which would have allowed 38 days of intermittent care. Currently, patients are not entitled to home care benefits if the exact duration of the service cannot be determined in advance of the benefit being provided. Expansion of the home care benefit to 38 days would allow sufficient time to determine the course of treatment necessary. It could also prevent the need to reinstitutionalize a patient in order to be eligible to receive services that could be provided less expensively at home, but for the current restrictions on home care eligibility. In addition, we recommend that Medicare be amended to allow for an extension of home care benefits under unusual circumstances, as currently permitted under existing HCFA guidelines, which allow for continued eligibility where the patient's need for daily care extends beyond 21 days and the need for daily care is limited. Clarifying these guidelines in statute could also reduce Medicare expenditures by preventing inappropriate short-term reinstitutionalization as the only available means for accessing services.

AAHA also applauds the Chairman's inclusion of adult day care benefits under H.R. 561. Like home care and respite services, adult day care is a viable alternative to institutional care for elderly individuals who are unable to function independently alone and who do not have access to informal caregiver support during the day. Since institutionalization often occurs as a last resort when no alternatives are available, coverage of adult day care service can provide a more appropriate form of service for individuals who need support and/or supervision but not full time institutional care. It can also vastly improve the quality of life for these individuals by prolonging the ability of their families to care for them at home. Furthermore, adult day care services are much more cost-effective than institutional services for individuals who need more limited support.

DISABILITY CRITERIA FOR ELIGIBILITY DETERMINATIONS

AAHA strongly supports the use of functional and cognitive measures to assess need for purposes of determining benefit eligibility. Under the disability model, benefit eligibility and benefit levels are based on the number of activities of daily living (ADLs) a person is unable to perform independently without human assistance. In the past several years, this model has become widely accepted by the public and private sectors as an appropriate measure for determining benefit eligibility. Support for this use of functional and cognitive criteria can be attributed to the objectivity and consistency in assessments obtained under this model.

The medical model of benefit determination leaves a great deal of room for subjective judgement on the part of the individual determining service need; decisions regarding service need and benefit allocation can be arbitrary. Furthermore, since the medical model involves subjective judgements, it becomes more difficult to hold providers accountable for decisions regarding service allocation and control of costs. Functional criteria have been found to provide greater reliability in rendering consistent, objective determinations of service need and have the potential to be more effective in controlling health care costs.

AAHA is also supportive of the actual ADL criteria included in H.R. 561 which provides for two levels of care. Since there is a correlation between the level of disabilities and the corresponding amount of resources required to address these disabilities, it is important to distinguish between level of disability and level of care. AAHA supports eligibility for community-based services based on two ADLs and eligibility for nursing home services on three ADLS. Proposals which would require individuals to be disabled in three or more ADLs to be eligible for home and community-based benefits effectively restrict access to lower level services for all but the severely disabled elderly. These individua.. often are more appropriately and/or cost-effectively served in a nursing facility.

PROSPECTIVE PAYMENT FOR SERVICES

AAHA recognizes the need for cost-containment strategies to control the spiraling costs of health and long-term care services. Such cost increases exacerbate the federal debt, interest payments on the federal debt and ultimately result in fewer dollars for important public services. The prospective payment system included in H.R. 651 has gained increasing appeal among the federal and state governments. The rationale for the implementation of prospective payment which, in the nursing home setting is based on the case mix of residents, is to match the different care needs of residents with the dollars required to care for their needs. While AAHA supports prospective payment in concept, the methods being used to establish prospective systems give us cause for concern. Emphasis is being placed on effective classification of resident groupings according to disabilities and treatment needs, totally ignoring linking patient classifications with adequate payments which reflect the true costs of care.

Historically, prospective payment systems have been designed and administered for cost-containment purposes. Such systems set prospective rates based on the "average-price" concept. Average-priced systems reward efficiency of facility operations, while quite often penalizing providers attempting to provide high quality resident care. AAHA is concerned that the intent of the OBRA '87 provisions on Nursing Home Reform could be jeopardized by focusing on resident classification in nursing homes and not measuring the actual costs of caring for residents.

The critical issue of how to determine the costs for care needed is exacerbated by the discrepancies between H.R. 651 and provisions in OBRA '90. OBRA '90 amendments include provisions for "Assurance of Appropriate Payment Amounts". Specifically, OBRA '90 states that facilities should be assured the payment amount necessary to ". . maintain the highest practicable physical, mental and psychosocial well-being of each resident. . .". Under OBRA '87, nursing facilities were instructed to provide this "highest level of functional care" and under OBRA 1990, facilities are instructed to be paid for providing the highest standard of care. AAHA's concern is that H.R. 651 states that payment will be made for "expenses which are reasonable and necessary for the maintenance of the physical, mental, and psychosocial well-being of the individual in the facility . . .". Specifically, the "highest practicable" standard is missing from H.R. 651. AAHA strong urges that the language in H.R. 651 be amended consistent with OBRA '90 amendments to prevent jeopardizing the quality reform goals of OBRA '87.

AAHA also strongly urges Chairman Stark and the Subcommittee to heavily scrutinize average pricing approaches used in case mix systems, to assure that quality of care and life standards are recognized in determining costs and payment levels. As current Federal law and regulations instruct, the appropriateness of payment rates should not be determined by budgetary and economic conditions, but rather on the basis of patient needs.

Finally, AAHA urges the Subcommittee to be ever mindful of the complexity of developing an equitable prospective payment methodology and to consider some additional factors in calculating costs and payments. While H.R. 651 does take into account the variations in case mix and area wage levels, AAHA believes that additional factors must be considered to ensure that the intent of H.R. 651 is met. Some of these factors include the construction of the inflation index; payment methods for ancillary services; the base year used to determine costs; the development of new technologies and standards of care; outlier payments for residents due to exceptional clinical circumstances; short-term versus long-term residents; and volume of services. Many of these more technical yet very important factors were included in the OBRA '90 provisions for the development of a prospective payment system for nursing facility services and should be incorporated in H.R. 651 as well.

While AAHA supports the expansion of Medicare benefits to meet the long-term care needs of our nation's elderly citizens, such expansion must be accompanied by adequate payments for services. The absence of payment levels sufficient to cover the costs of care effectively levies a "tax" on providers for the subsidization of public programs.

AAHA commends this Subcommittee for your leadership last year in the successful enactment of 1990 budget provisions requiring that the Medicare SNF cost limits be updated using 1988 data; and further, that these cost limits be updated every two years henceforth. Since the Health Care Financing Administration (HCFA) has not complied with that law, however, we request that you encourage HCFA to issue the new regulations governing Medicare payments in a timely fashion. This will assure that the fruits of your efforts be realized as quickly as possible. Currently, Medicare SNF cost-limits are still based on 1982-1983 data and long-term care providers will continue to be paid on this basis until the new regulations are promulgated. Furthermore, we urge that no additional expansion of Medicare benefits take place until the cost limits are updated and the true costs of long-term care service delivery are recognized.

CASE MANAGEMENT

AAHA has long supported the use of case-management as a vehicle for promoting the most appropriate match between client needs and services and to promote cost-effective delivery of health and long-term care services. Case-management strategies are used in HMOs and CCRCs to manage and

coordinate care through a single provider entity. This entity is responsible for assessing each resident's individual needs and allocating the most appropriate and cost-effective services to meet these needs. Moreover, the greater the diversity of services available to the case-manager, the greater the opportunities for maximizing the appropriateness and cost-effectiveness of client services. H.R. 651 has the potential to achieve both of these goals by incorporating case-management functions in the long-term care delivery system and providing coverage for a wide range of supportive services, including adult day care which currently is not covered under Medicare.

Notwithstanding AAHA's support for case-mangement strategies, we have several concerns related to the assessment and care planning process included in the Mediplan long-term care program. H.R. 651 would require eligibility assessments, comprehensive needs assessments and plans of care to be conducted by independent case-management agencies. It would also require nursing facilities to use such plans of care instead of those required under the nursing home reform provisions of OBRA. We are pleased to see an attempt to eliminate duplication of effort, but no assessment and care plan developed by an external case-management agency will be able to supplant treatment plans implemented by the providers with the professional responsibility and legal liability for resident care.

Nursing homes are required by law to provide services to meet the highest practicable physical, mental and psychosocial well-being of their residents. They cannot assure compliance with that requirement by relying on assessments and care plans conducted by agencies which are not accountable to the nursing facility. We strongly recommend that case-management agencies restrict their assessment to determining the type of impairment and functional status of residents; the availability of service arrangements and caregiver support; and the amount, duration and scope of services required by the resident. Individual nursing home, home care and community-based service providers should maintain their current assessment and care planning responsibilities, as required under OBRA '87.

We also recommend that the uniform instruments required for assessment and/or care planning under H.R. 651 build upon and not duplicate those already required under OBRA '87.

AAHA also urges the Subcommittee to consider the impact of certain case-management provisions upon the residents and providers of CCRCs and other managed-care settings. Specifically, AAHA is concerned about the prohibition against case-management by an organization related to any long-term care providers rendering services to clients using case-management services. CCRCs are an example of an innovative health care model that integrates the financing and delivery of long-term care services ranging from independent living to skilled nursing care. CCRC services often are offered on a prepaid basis. A fundamental component of the CCRC model is a strong care-management function. Case-managers in CCRCs conduct resident assessments and facilitate access to a wide range of supportive and skilled services. To require CCRC residents to use the case-management services of an outside agency to gain access to services -- services that they may already have paid for and which are offered by their residential community -- is inefficient. AAHA also believes that it would be counter-productive to the cost-containment goals of the care-management provisions in H.R. 651.

FINANCING LONG-TERM CARE COSTS

AAHA's final comments regarding the long-term care legislation under consideration by this Subcommittee relate to methods for financing services. AAHA is concerned that the proposal in H.R. 561 for financing the new long-term care benefits will place an undue burden on those individuals in lower income categories. The two percent tax on modified gross income of individuals with incomes over $16,000 (or $32,000 for couples) is a regressive scheme which will adversely impact those in lower earning categories. More progressive alternatives would be to increase or lift the social security wage cap for OASDI taxes or to increase the surtax on gifts and inheritance transfers.

In summary, AAHA commends the Chairman and Subcommittee members for introducing important measures to improve our nation's long-term care system. We believe that a mixture of short-term and comprehensive measures are required to ultimately improve the elderly's access to long-term care coverage and financing. Incremental Medicare changes such as elimination of the three-day prior hospitalization, expansion of the nursing facility benefit and a modest expansion of home care benefits will provide the elderly with interim relief until more comprehensive changes are implemented. AAHA stands ready to assist the Subcommittee in any way we can to effect these critical changes to our nation's long-term care system.

VW/214

Chairman STARK. Thank you very much.
Dr. Willging.

STATEMENT OF PAUL R. WILLGING, PH.D., EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION

Mr. WILLGING. Thank you, Mr. Chairman.

I, too, want to thank you for giving us the opportunity to testify with respect to H.R. 651. And perhaps even more critically, with respect to H.R. 1200. In fact, I would like to at the outset answer a question you posed not to me, but to some of the previous witnesses as to whether it makes sense to wait for the revolution or perhaps do something now.

I clearly applaud your decision that there are incremental changes that can be enacted. That we don't need to wait for a revolution which may not come in our lifetimes.

I think it is with obvious trepidation, Mr. Chairman, that I bring up from the past some of the memories related to the enactment and subsequently the repeal of the Medicare Catastrophic Coverage Act.

I think it was painful for all of us—providers, consumers and Members of Congress. I think though, that it is clear that in the hectic and frenetic period during which the repeal was legislated, we threw out a lot of babies with that bath water.

It is quite clear that one of them was indeed the 3 day prior hospitalization requirement. I think in retrospect, and perhaps even at the time, we recognized that particular aspect of the SNF enhancement was not, in fact, a culprit with respect to the cost impacts.

Indeed, one could argue, as I will in my remarks, that it might indeed save dollars if you look at the net cost to the Medicare program. But even more important, as you pointed out in your opening comments, it is ludicrous, it is inhumane. it is absurd.

I will try to get off the fence here any minute now. It is clearly bad medical practice to force a resident, a patient, a Medicare beneficiary through arbitrary and capricious hoops just so he or she is eventually going to have access to a benefit to which he or she is entitled and which his or her medical conditions makes quite proper.

It is important to remember, as you clearly have, that 3 day prior hospitalization was only one of four or five component parts of that admittedly high level of excess cost that was attributable to the SNF expansion.

In fact, one has to remember, that the prior year with the publication of the new coverage manual in April 1988, in a 6 month period we already saw a doubling of the SNF claims submitted through the intermediaries through the Health Care Finance Administration.

Beyond that, the SNF enhancement included a major change in copayments. It included a change in the way we defined the temporal parameters of the benefit from a spell of illness concept to an annual yearly concept and an expansion of the benefit from 100 to 150 days.

In discussion regarding the repeal, the CBO was asked how they would account for the $13 billion excess cost above and beyond the

original estimates. They pointed out already at that time 70 percent of that, $9 billion, related to the copayment.

Only 15 percent, about $1.9 billion over a 5-year period, related to the three day prior hospitalization.

What they in that analysis did not mention, assuming $1.9 billion had some relationship to reality, that it was offset clearly by a reduction in otherwise used hospital stays, a reduction in the accompanying part B payments to physicians and a reduction in terms of the Medicaid payment.

Chairman STARK. Let me ask you this. You are closer to the CBO estimator right now than I was. Didn't they figure that the reason you don't get any savings on the hospitalization was that there is some assumption that the people were in under a DRG previously so that it was a question of how long they would stay?

In other words, was that taken into account, that hospitals got clipped for that and not HCFA?

Mr. WILLGING. It is hard to say.

Chairman STARK. Actually, it would be a cost if you just sent them to a hospital for something you knew was unnecessary. But if they went in for a 1 day DRG and got stuck in there for 3 days, then the hospital has to swallow the cost and not HCFA?

Mr. WILLGING. Ultimately, the hospital is paid the entire DRG related to an average stay, which is actually higher than 3 days. It is 4 or 5 days. That was one more reason why there were major offsets.

As we have done our analysis—and we are waiting for a critical piece of data that the Health Care Finance Administration has not provided—we have taken a worse case scenario. We have said let's take every additional SNF admission between 1988 and 1989. Let's assume all of that is induced by catastrophic.

Then let's take a conservative number of hospital admissions. We come out at around 15,000 per month, which as it turns out, not ever having seen it before, my colleague has suggested about what their experience in the HMO that they run confirms.

We see that approximately $1.2 billion per year increase in SNF costs is compensated for by over a $1.2 billion decrease in hospital stays avoided. We add then another $250 million to that, which is the reduction in Medicaid payments in which, of course, the Federal Government shares 55 percent, for a net saving of around $250 million per year.

We have asked the Health Care Finance Administration for two pieces of data. We had, after all, a natural experiment in 1989. For the first time we didn't have to give a gut reaction to whether this would save or cost money. We have a natural experiment.

My red light has gone on. I will still finish the question. That is, HCFA must tell us how many admissions to nursing homes in 1989 were accompanied by a three day prior and how many were not, straight from the home or the community. Once we have that data, we have all agreed on the formula into which we will plug the data.

By "all," I mean the American Association of Retired Persons, CBO, the American Institute, the American Health Care Association.

At our most recent meeting, HCFA actuaries agreed on the methodology. We are waiting simply for that one piece of paper.

Chairman STARK. You said something about the data was agreed to. So what you are telling me is that CBO, HCFA and others have concurred with your assumptions? All you are arguing about is the data that goes into the base?

Mr. WILLGING. Absolutely. Initially, HCFA even published this critical piece of data.

Chairman STARK. How did you ever get OMB——

Mr. WILLGING. OMB was the only one not there.

Chairman STARK. Because they wouldn't agree to anything.

Mr. WILLGING. That is correct. That is why we chose not to invite them.

Chairman STARK. Alright. We are just waiting for the numbers?

Mr. WILLGING. Yes, as we so often are with the Health Care Finance Administration.

As soon as that number is available, we have all agreed on the methodology. I would be willing to bet we will see at worst a cost wash. In all likelihood, there will be a savings to the Federal Government

Chairman STARK. I bet you OMB triples your estimate.

Mr. WILLGING. I sometimes share those views. Of course, I have to lobby them on occasion, so I would never say anything like that publicly.

That concludes my remarks, Mr. Chairman.

[The prepared statement follows:]

TESTIMONY OF PAUL R. WILLGING, Ph. D.

EXECUTIVE VICE PRESIDENT

AMERICAN HEALTH CARE ASSOCIATION

BEFORE THE

WAYS AND MEANS HEALTH SUBCOMMITTEE

MARCH 4, 1991

Mr. Chairman and Members of the Subcommittee, I am Paul Willging, Executive Vice President of the American Health Care Association (AHCA), the largest association representing the nation's nursing homes. AHCA is a nonprofit federation of fifty one state affiliates which represents approximately 10,000 individual for-profit and philanthropic nursing and allied health care facilities who provide care to more than 1,000,000 Americans. I would like to commend you, Chairman Stark, and members of your subcommittee, for holding this hearing today on long-term care and proposals to improve Medicare's skilled nursing facility and home health benefits. I would also like to express my appreciation to you for letting me testify specifically on your proposal to eliminate the three-day hospital stay requirement for skilled nursing facility services.

There are three issues I want to discuss with you today in regard to the three-day stay. The first issue is the background of Medicare and the passage of the Medicare Catastrophic Coverage Act (MCCA) of 1988 and the number of changes in the Medicare SNF benefit that took place. The second issue is the three day prior specifically and why repealing it makes sense from a policy perspective. The last issue is the ongoing efforts to determine costs or savings to the repeal of

the three day prior hospital stay requirement.

BACKGROUND

Medicare has been in effect since 1965. It has been our understanding that SNF benefit be a post-hospitalization benefit, and as part of Congress' effort to insure that the SNF benefit was for post-acute care, the three day prior hospitalization stay was instituted. That three day stay was to be used to evaluate the need for qualifying for the benefit. In order to further control utilizati , Congress also required a copayment after the 20th day. The three-day qualifying stay provision was developed to serve a gatekeeping function to prevent over-utilization of skilled nursing facilities.

The Medicare SNF benefit remained virtually unchanged from a legislative viewpoint until 1988, although numerous regulatory issues were debated and litigated between the nursing home industry, consumer advocates, and the federal and state governments. However, 1988 proved to be a landmark year in which a major regulatory change and several legislative changes were made to the Medicare SNF benefit.

In April of 1988, the Health Care Financing Administration (HCFA) implemented clarifications of the instructions to intermediaries regarding Medicare coverage standards for the SNF benefit. HCFA's publicly stated position was that the clarifications would neither expand coverage nor lead to an increase in program outlays. Advocates for Medicare beneficiaries, provider organizations, staff in intermediaries, and a variety of other parties hailed the new instructions as increasing eligibility for the new benefit and ending the "uneven and unfair"

administration of the benefit. Six months after the release of the new instructions, the monthly claims for Medicare SNF services had risen from $49 million in March 1988 to $96 million in November 1988.

Later in the same year, the Medicare Catastrophic Coverage Act (MCCA) of 1988 was passed by Congress. It greatly expanded a number of benefits to the elderly. Specifically regarding the skilled nursing home benefit, three changes were enacted to increase the utilization of nursing home usage. The following changes were made effective January 1, 1989:

o Eliminated the eligibility requirement of a three-day hospital stay;

o Increased the maximum coverage stay from 100 days during a period of illness to 150 days per calendar year; and

o Changed the structure of copayments from a relatively high copayment (a projected $70 per day in 1989) for the twenty-first through the one-hundredth day of a SNF stay to a relatively low copayment (an actual copayment of $22.50 per day in 1989) for the first through the eighth day.

These changes brought about what was expected and desired---an increase in the use of skilled nursing facility benefits. Four months after the provisions went into effect, monthly Medicare SNF expenditures had risen from $96 million in November 1988 to $223 million in April 1989. And, as we all know, expenditures increased significently to the point where the MCCA was repealed and the perceived cost containment features of the three day stay and a changed copayment were reinstituted.

THE REPEAL OF THE THREE DAY STAY IS GOOD PUBLIC POLICY

We are here today to point out the reasons why the reinstitution of the three-day prior hospital stay is not sound from a public policy standpoint nor is sound economically. We believe the repeal of the three day stay was not an expense but a cost savings to the program, and more importantly, that it makes sense from a policy perspective. Let me first address some basic policy reasons why this restriction is bad policy and should be eliminated:

1. The Medicare program was founded on the premise that the aged in need of medical care should get that care. All beneficiaries are entitled to the level of care he or she needs without artificial barriers. The role and function of a SNF has changed since 1965 when Medicare was first passed. Now many individuals need care which can be most effectively provided in a SNF. A diabetic or ventilator dependent patient should have the right to the most appropriate level of care he or she needs, and should not be forced into situations and placements that are costly and unnecessary.

2. The three day stay requirement hampers the ability of the physician to choose what is best for his patient. If a doctor feels it is in the best interest of the patient to be in a rehabilitative setting, then the physician and patient should be accommodated. Under the current system, a physician has no choice but to admit a patient to the hospital and then into a SNF in order to obtain SNF Medicare services---even though it may not have been necessary for the patient to go to the hospital in the first place.

3. In a small number of cases, the three day stay rule

causes unnecessary and burdensome transfers into and out of the hospital from a SNF. For example, lets look at a patient who encounters a stroke while in the SNF. To qualify for the Medicare benefit, that patient must leave the SNF in which treatment is being given and return to a hospital for three days only to be sent back to the SNF for rehabilitation. The patient endures an unnecessary transfer and acute hospital stay for only three days and returns to the SNF in a much more confused state than necessary.

Another example is a patient who after a stay for a hip replacement in the SNF is discharged to home. The patient falls again at home and has to be readmitted to the acute hospital for three days and is then admitted to a SNF for a continued rehabilitation therapy, even though the doctor and the patient felt comfortable with the service at the less costly SNF.

COST ESTIMATES

In addition to looking at the public policy issues, the critical factor in making a decision to remove this seeming cost containment requirement is the obvious factor of cost. The basic question is: does the three-day stay save money? We say no. Our reasoning is found by taking a step back in history and looking at the MCCA.

The CBO had estimated that the legislation would increase federal expenditures by approximately $32 billion dollars between FY 1989 and FY 1993 when the bill passed in November 1988. The administration actuaries estimated that it would cost $36 billion over the same period. The seeming difference between the CBO and actuaries estimates was the much publicized difference between the cost of the new Medicare

prescription drug benefit included in the catastrophic legislation. In July 1989, based on data that became available in June 1989, CBO revised its estimate of the prescription drug benefit and raised its estimate of the five year cost to $37 billion. These new cost estimates added fuel to repeal the legislation, to a firestorm of complaint coming from the elderly who did not like the tax structure set up to pay for all the new benefits.

The problem was then compounded barely one month after the prescription drug re-estimate. CBO staff received data that showed a dramatic increase in Medicare SNF outlays. For the following two weeks, a substantial number of CBO and administration staff searched for definitive information on: (1) what was causing the increases in SNF expenditures and (2) how much more the expenditures would increase during the remainder of 1989 and beyond. Little data were found at that time.

In September of 1989, CBO released a memorandum that stressed the uncertainties surrounding the estimate and the lack of data, but raised the cost of the catastrophic legislation from $37 billion to $48.2 billion over the five year period. Thirteen billion of the $48.2 billion was the SNF provisions of MCCA. CBO showed that 70 percent of the $13 billion was due to the change in copayments, 15 percent was due to the three day prior repeal, 10 percent was an irreversible "ratchet effect" (wherein the legislation had permanently changed the behavior of providers toward increased use of Medicare over Medicaid coverage), and 5 percent was due to the increase to 150 days. Two weeks later, the administration raised its estimate from $36 billion to $49 billion. After these estimates had been received and released to the Congress, the process to repeal the catastrophic bill accelerated.

At the end of 1989, there was firmly, and we believe erroneously, fixed in peoples minds that the costs of the SNF benefit were enormous and the cost controls of co-pay and three day stay had to be reintroduced.

TOWARD A BETTER ESTIMATE

Our contention has always been that the data would not support the argument that eliminating the three day stay was one of the culprits in the cost overruns. We, to the contrary point out that in the rush of making estimates certain offsets were forgotten.

Since the flurry of activity in 1989, a variety of data have become available regarding what actually happened in 1989. To make use of these data, we employed an objective, outside consultant, Donald N. Muse Ph.D., to review the issue and to prepare an estimate of the actual cost or savings associated with the repeal of three day prior hospital stay requirement. His preliminary analysis concluded that the repeal of three day requirement would in fact save $1.7 billion over the five years between FY 1992 and FY 1996.

The dramatic difference between this estimate and the 1989 CBO estimate results from CBO ignoring the cost savings from fewer people being sent to hospitals in order to qualify them for a Medicare SNF stay in their earlier estimates. These Medicare savings, and the associated Medicaid program savings, were not included in the 1989 estimate because CBO felt that it had insufficient evidence to estimate them even though their presence had been recognized even before the Medicare program was passed. We think this to be an unfortunate oversight, especially since even at the Medicare programs inception, people recognized the SNF

benefit reduced hospital costs and utilization. In fact, in 1965 House hearings, the Social Security actuaries testified that they recognized the "the inclusion of these benefits reduced hospital utilization." The insurance industry also agreed with the actuaries and further testified that the addition of the three day prior hospital stay requirement would increase hospital admissions.

Dr. Muse has then proceeded to relook at the numbers for us. Using new data and recognizing the hospital offset, his preliminary estimate showed that Medicare Part A & B would be saved approximately $1.2 billion in 1992 in avoided hospital stays and associated physician costs if the three day prior hospital stay requirement were repealed. At a total cost of $7,280 per hospitalization (plus physician costs) in FY 1992, it is easy to see that it would take relatively few avoided hospitalizations to save Medicare large sums of money.

A second point to ponder in looking at estimates, is State Medicaid programs. The Federal government would save $225 million because persons who would have been covered in an ICF/SNF bed funded by the Medicaid program are either in a hospital or SNF bed being paid for by Medicare.

Of course, repeal of three day stay does cause some increase in Medicare costs because beneficiaries not previously entitled to and needing the SNF benefit would receive the benefit. These additional costs include $800 million in needed SNF care for beneficiaries currently not receiving such care and $400 million for SNF care for beneficiaries who will stay in a SNF rather than be cycled through an unnecessary and expensive hospitalization. The net

result of these costs and savings ($1,200 million + $225 million - $800 million - $400 million) is $225 million in savings to the federal government in FY 1992 alone.

These estimates are obviously the result of a number of assumptions and calculations, and we did not feel comfortable in using them without an outside review. Furthermore, we are concerned that the numbers be agreed to by all those concerned so that all biases be rendered neutral. Consequently, the preliminary estimate of savings has been reviewed by experts from CBO, HCFA, and the private sector. We feel comfortable with the savings figure, but we are awaiting verification through an important piece of data from HCFA that the experts agree is critical to the final estimate. Based on our own staff work we believe that the data will show in the worst case scenario that the repeal of three day prior hospital stay will save at least a small amount of money or break even. As soon as we receive the data from HCFA, we will forward the final estimate to the Committee and others concerned with the repeal of three day prior hospital stay requirement.

In conclusion, Mr. Chairman, we believe the three day prior hospitalization requirement should be eliminated. It is an arbitrary and capricious requirement and does not provide beneficiaries with access to the appropriate level of care.

The three-day stay has been wrongly touted as a cost-saving device when in reality it stimulates additional, unnecessary, and costly hospital stays. It does this to a much greater extent than it is protecting the Medicare system from an influx of new SNF admissions for beneficiaries who need the services. The

combination of added cost and arbitrary restriction of Medicare benefit leads us to the conclusion that the three day stay must be repealed.

Again, I appreciate the opportunity to testify before you today. I look forward in working with you on this issue. I will be happy to answer any questions you may have.

Chairman STARK. Thank you.
Ms. Bäby.

STATEMENT OF FRAN BÄBY, PRESIDENT, FIRST CHOICE HOME HEALTH AND PERSONAL SERVICES INC., COLUMBUS, OHIO, FOR THE NATIONAL ASSOCIATION FOR HOME CARE

Ms. BÄBY. On behalf of the National Association for Home Care, we also thank you for the opportunity to testify here today. My purpose for being here is to testify on two different issues.

First, long-term care. Second, the intermittent care proposal currently being considered by this committee.

The National Association for Home Care strongly supports the establishment of a national long-term care program based on home health care. We feel it is a humane and cost effective activity and reinforces and supplements services which families are already providing.

We specifically want to commend you for introducing H.R. 651, which contains essential elements of a long-term care program. Specifically, home care as the basis, functional disability rather than age, as the key to eligibility, and a wide range of comprehensive services.

Nursing home care coverage, we feel, should be limited only to those individuals for whom home care is not possible. A long-term care program should be federally funded and structured on a social insurance model. Financing should be progressive and as broad based as possible.

And last of all, safeguards should exist for cost containment and quality assurance.

We also would like to expand our comments on two different provisions with regard to the proposed long-term care legislation. First of all, co-payments. The National Association for Home Care has consistently opposed cost sharing because of its burden on Medicare beneficiaries and because of the additional administrative costs we feel would be passed on eventually to the program.

And secondly, the case management issue. Case management has different meanings for different people. We believe a balance can be achieved in which the provider remains responsible for care management and the payer can carry out utilization management responsibilities without unnecessary costly and administratively burdensome duplication of client care planning and review functions.

My second point in speaking to you today deals with the intermittent care definition under the current Medicare benefit. Dr. Willging talked about hoop jumping, I think this is the ultimate for the beneficiary in order to qualify.

While a legislative solution to the crisis in long-term care is not imminent, there are interim steps Congress can take to ease the burden on the beneficiaries. One of the steps Congress could take is a modest increase in the expansion of home care benefits. We commend you, Mr. Chairman, and your colleagues for reintroducing this legislation again this year. The intermittent care definition is of particular importance because it determines the nature and frequency of home care to the beneficiaries.

When the Medicare home care benefit was created, Congress stated that covered care was to be intermittent, but did not specifically define what constituted intermittent care in the regulations.

It left those limits of definition to the Health Care Financing Administration. What we have found over the years is that the Health Care Financing Administration through its administrative process with the fiscal intermediaries defines home care on a very arbitrary basis.

This arbitrariness was carried out to such a degree that in 1987 the National Association for Home Care sued HCFA in what is now known as the *Duggan* v. *Bowen* suit or the Staggers law suit, after Congressman Harley O. Staggers.

Under the *Duggan* decision, the definition of daily care for purposes of coverage only was expanded to seven days. What *Duggan* did not define, which was felt to be taken care of under the Medicare Catastrophic Act, was the eligibility criteria. However, Mr. Chairman, as you well know, the Medicare Catastrophic Act was repealed, resulting in a situation where a person may be covered, but who on the outset is not defined to be eligible because of the strict provisions under the current definition of intermittent care.

If there is no certainty at the outset through the course of treatment for a patient needing care for more than 5 days, the patient is entitled to no home care at all.

The proposed intermittent care language is crucial for two reasons, first, it would correct the current inconsistency and resolve confusion from differing definitions of daily care for purposes of eligibility and coverage for home care.

It would also provide a guaranteed number of days of daily care to deal with diagnosis and procedures that require daily home care but did not require institutional care where the exact duration of care cannot be determined with certainty at the onset of care.

I alluded earlier that this is a good example of hoop jumping. I think it is a situation that is clearly very hard to explain to the beneficiary.

It is also very difficult to define to a physician. For instance, we can let somebody know at the outset that they would need daily coverage and may qualify because of a coverage issue.

But if they are not eligible to being with, they are denied the home care benefit from the outset.

I see this a lot. Remember the entertainer on the "Ed Sullivan Show" who used to try to keep the plates going on those little spindles? On a daily basis, Mr. Chairman, that is how I feel when interpreting the intermittent criteria to my patients.

It is very difficult to explain to them that they qualify because of their need, but because Medicare has not clearly spelled out whether they are eligible or not and because their physician on the outset cannot absolutely guarantee a finite period of time by which they will rehabilitate, then they are basically being denied the home care benefits under Medicare.

In my written testimony I have two examples of intermittent care cases that were denied recently in my agency. The first one was improperly denied. However, because of the internal review process from the fiscal intermediary, it was denied because the patient needed 7 days a week care for a period of 13 visits.

The reviewer saw the 7-days-a-week care and automatically denied coverage.

The second example is much more complicated. We had a finite period of time initially where there were 7 days when the physician felt that the patient could be seen daily by home care. After that his orders basically were on an "as needed" basis and changed every 2 days.

Because he could not on the outset clearly define that the patient would be better within a certain period of time, and as it turns out, it was 14 days, her coverage was denied under Medicare and it was sent to appeal.

We would further recommend amending the proposed intermittent care legislation to include language clarifying that coverage can be extended under unusual circumstances beyond the allotted time.

We thank you for the opportunity to speak today both on House bill 651. But we also are very much in support and commend you for your efforts to clarify a very complicated and misunderstood issue under the Medicare home care benefit, intermittent care.

Thank you.

[The prepared statement follows:]

Statement of Fran Baby, President

First Choice Home Health and Personal Services, Inc.
Columbus, Ohio

on behalf of the

NATIONAL ASSOCIATION FOR HOME CARE

on

Long-Term Care and
Proposals to Improve Medicare's
Skilled Nursing Facility and
Home Health Benefits

before the

Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C.

March 4, 1991

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My name is Fran Baby. I am President of First Choice Home Health and Personal Services, Inc., Columbus, Ohio. I also serve as chair of the National Association for Home Care's (NAHC) Government Affairs Committee.

The National Association for Home Care represents approximately 6,000 home health agencies, homemaker-home health aide organizations and hospices. On behalf of these organizations and the beneficiaries they serve, I would like to thank Chairman Stark and the Health Subcommittee Members for holding this very important hearing on long-term care and proposals to improve Medicare's home health benefits.

My testimony today details NAHC's strong support for a federally funded universal long-term home care program and for the MediPlan Long-Term Care legislation that you have introduced. I will also address my comments today to another important issue, that of clarifying the "intermittent care" definition in the Medicare home care benefit.

LONG-TERM CARE

NAHC strongly supports the establishment of a national long-term care program that is based on home health care. Home care is a humane and often cost-effective alternative to institutionalization. It reinforces and supplements the care provided by family members and friends and encourages maximum independence of thought and functioning as well as the preservation of human dignity.

Estimates indicate that between 9 and 11 million Americans of all ages require long-term care because of chronic illness or disability that render them helpless to perform basic tasks of daily living without assistance. Neither Medicare nor private insurance provides adequate protection against the costs of long-term care. A million Americans a year, two-thirds of them elderly, go bankrupt trying to meet the cost of long-term care. Only the most wealthy of Americans are insulated from these financially devastating costs.

The need for long-term care is expected to increase substantially as a result of several factors: the burgeoning growth of the elderly population; increased usage of high technology and new medical breakthroughs that may extend the lives of more mentally retarded, developmentally disabled and physically disabled persons; increased survivorship of low birthweight children; greater longevity for children with terminal chronic illness, and earlier detection of chronic health problems; and the growth of the number of persons with AIDS.

Last year, the U.S. Bipartisan Commission on Comprehensive Health Care, also known as the Pepper Commission, outlined the significance of the long-term care problem and called for swift and comprehensive reform. Further, the Commission set forth a mandate that appropriately targeted home care as the best answer to the nation's long-term care needs. The National Association for Home Care endorsed the Pepper Commission's proposal as the standard by which other long-term care legislation should be compared.

Mr. Chairman, NAHC commends you for introducing H.R. 651, which contains the essential elements that should be included in any long-term care plan that ultimately is enacted. Specifically, NAHC supports the following provisions of H.R. 651:

* Home care should be the basis of the long-term care program;

* Eligibility should be keyed to functional disability (including cognitive impairment) rather than age;

* Services should include a comprehensive range of in-home skilled nursing, physical therapy, occupational therapy, speech therapy, respiratory therapy, medical social services, homemaker-home health aide and adult day care, individual and family caregiver education and training necessary to permit a patient to remain at home (NAHC would encourage the addition of respite care to this list);

* Nursing home care coverage should be limited only to those individuals for whom home care is not possible;

* The long-term care program should be federally funded and structured on a social insurance model with benefits available to all Americans regardless of their ability to pay;

* Financing should be as progressive and broad-based as possible and should be designed to keep pace with benefit growth; and

* Safeguards should exist for cost containment and quality assurance.

I would like to expand my comments on two additional provisions of H.R. 651 dealing with copayments and case management.

Copayments -- The National Association for Home Care has consistently opposed cost-sharing because copayments unfairly increase the burden on Medicare beneficiaries who already are required to make large out-of-pocket expenditures to finance their health care. Imposing cost-sharing for home health visits would result in some clients going without needed care, thus increasing the number of hospital admissions that could have been prevented by earlier intervention. Further, home health agencies and/or the government would be put in the position of collecting coinsurance from the elderly. The administrative costs in doing so would be enormous, and would necessarily be passed along to the government. This would more than offset any savings that are anticipated from the implementation of coinsurance.

Case Management -- There is a good deal of ambiguity about the inclusion of case management activities in a long-term care program. The confusion results in part because "case management" has different meanings for different people. Case management, as a means of maintaining fiscal accountability and integrity, is appropriately a function of the government. Case management, as a means of determining which services best meet the needs of a client, is appropriately a function of medical professionals.

NAHC believes that the division of responsibilities between payors and home care agency providers should recognize the payor's obligation to protect the program against excessive costs while acknowledging the caregiver's responsibility for managing the client's care and serving as the client's advocate. It is the agency caregivers who are trained for assessments and are in personal contact with the client on a continuing basis. They are the ones ultimately responsible to the client for his or her care.

NAHC believes that a balance can be achieved in which the provider remains responsible for care management and the payor can carry out its utilization management responsibilities without an unnecessary, costly and administratively burdensome duplication of client care planning and review functions. For example, New York State's highly successful Nursing Home Without Walls program has made use of joint assessment visits by professionals representing provider and payor. Another example is the use of the interdisciplinary team within the Medicare hospice benefit as a form case management. A prior approval for the utilization of services, after an assessment has been done by the home care agency who provides a plan of care, could also serve as an effective safeguard.

INTERMITTENT CARE

While a legislative solution to the crisis in long-term care may not be imminent, there are interim steps that Congress could take that could ease the burden on beneficiaries. Included as part of the Medicare Catastrophic Coverage Act (MCCA) was a modest expansion of the home care benefit. This provision would have defined "intermittent care" to include daily care (up to 7 days a week) for up to 38 days. It was first introduced as separate legislation in 1983 and was reintroduced in subsequent years and garnered increasing support until it was finally included in the MCCA. As you know, it was lost when the MCCA was repealed. We commend the Chairman of this Committee and Mr. Gradison and their colleagues for reintroducing this measure last year and again this year.

The "intermittent care" issue is of particular importance because it determines the nature and frequency of home care to millions of elderly, infirm and disabled beneficiaries. The legislative provision was intended to ensure that the Medicare home care benefit was not being unjustifiably limited by the Health Care Financing Administration (HCFA) and its fiscal intermediaries (FIs) through restrictive and inconsistent interpretations of the term "intermittent care."

In creating the Medicare home health benefit, Congress stated that covered care was to be "intermittent" but did not specifically define what constituted "intermittent care." HCFA never promulgated regulations for public comment in the Federal Register to define the limits of intermittent care, but did issue guidelines to the FIs who process claims for home care providers. What resulted were varying and inconsistent interpretations by FIs as to what constituted intermittent care. The restrictions in eligibility and coverage for the Medicare home care benefit became so severe that 14 members of Congress, the National Association for Home Care, and 20 individual and agency plaintiffs brought suit against the Department of Health and Human Services in the U.S. District Court for the District of Columbia in 1987, at the same time Congress was considering the intermittent care provision in the context of the MCCA.

Federal Judge Stanley Sporkin ruled for the plaintiffs in this case, Duggan v. Bowen (also known as "the Staggers lawsuit"), stating that the Administration was illegally denying Medicare benefits to thousands of elderly people needing daily home care. Under the Duggan decision, the definition of daily care for purposes of coverage for home care, once eligibility has been established, is 7 days per week. The court was silent as to the definition of daily care in the context of the intermittent requirement for purposes of eligibility, since the Congress had included the "intermittent care" provision defining daily as 7 days a week in the MCCA.

When the MCCA was repealed, the result in terms of the intermittent care requirement was that there are now two different definitions of daily care -- one for eligibility for home care and one for coverage. For purposes of eligibility for service, the definition of daily care is 5 to 7 days a week,

since the MCCA was repealed. This means that if a patient requires care 5 days per week, he or she is receiving "daily" care for purposes of the intermittent requirement. After Duggan the definition of daily for purposes of coverage for care is 7 days a week. It is important to recognize that if eligibility is not established, there is no coverage. Thus, the more restrictive definition of daily for purposes of eligibility takes on its significance.

Currently, if no certainty can be attached at the outset to the course of treatment for a patient needing care for 5, 6, or 7 days a week, the patient is entitled to no home care services at all. For example, if a patient is released from the hospital with a draining wound and the physician cannot predict with certainty at the outset how long the patient will require daily visits to change the wound dressings until it heals, the patient is denied eligibility for any home care. This could necessitate reinstitutionalization of the patient at a far greater cost to the Medicare program. Under the provision allowing for 38 days of 7-day-a-week care this patient would receive care for up to this 38-day period which would allow sufficient time for observation as to the patient's progress and the time when the number of visits could be reduced.

The "intermittent care" language is thus crucial for two reasons:

(1) It would correct the current inconsistency and resultant confusion from differing definitions of daily care for purposes of eligibility and coverage for home care; and

(2) It would provide a guaranteed number of days of daily care to deal with diagnoses and procedures that require daily home care but do not require institutional care where the exact duration of care cannot be fixed with certainty at the onset of care.

A vast number of current "intermittent care" denials are for wound care cases. In these instances, daily care is required to change wound dressings, but because healing time is uncertain at the onset of care, coverage is being denied altogether. Another frequent example involves the administration of heparin. In such instances, a patient may be recovering from an embolism and requires daily heparin injections to thin the blood so as to inhibit clotting. Monitoring of blood levels is crucial so that a proper level is reached and the blood is not too thin (causing bleeding) or too thick (causing clotting.) Because daily care is required to establish appropriate levels and it is unclear at the outset when stabilization will be reached, care is denied as "not intermittent." In the wound care and heparin examples, allowing 38 days of 7 day a week care would permit the physician to better determine recovery or stabilization time for the patient. Currently, these patients are determined ineligible for home care.

Below are just two examples of "intermittent care" cases denied in my agency recently:

A 76 year old male diagnosed with lower GI hemorrhage and colon cancer was referred by his physician for daily wound care at home. The patient's wife, due to her advanced age and poor eyesight was unable to perform the care appropriately. The physician ordered daily (7 days a week) wound care for 13 visits. The care was denied because it did not meet the definition of intermittent or part-time care. This case was improperly denied, but it serves as an illustration of the confusion over eligibility criteria that currently exists.

A blind 85 year old diabetic female diagnosed with a neurogenic bladder condition was referred to home care by her physician for straight catherization twice a day for 7 days. At the end of the 7 day period, her test results revealed that straight catherization was still required to avoid residuals left in the bladder and infections. The physician ordered additional

catherization but was unable to determine an exact date of termination of services. At the end of the second week test results revealed her residual was within normal limits and the patient was discharged. The care was denied because the physician was unable to predict the exact date of discharge and because the care needed was daily.

We would further recommend amending the proposed intermittent care legislation to include language clarifying that coverage can be extended under unusual circumstances. This would codify existing guidelines which allow for continued eligibility where the patient's need for daily care extends beyond 21 days and the need for daily care is not indefinite. The purpose behind the HCFA guideline is to allow patients to remain at home and to avoid costly reinstitutionalization.

Summary

Long-term care is one of the most devastating problems America faces today. With rapidly changing demographics and technology, this problem will only get worse unless prompt action is taken. NAHC supports the enactment of a federally funded national long-term care program under which disabled and chronically ill individuals of all ages, regardless of their ability to pay, are eligible for a broad range of home care services. As an interim step to ease the burden on beneficiaries, NAHC recommends that Congress clarify the definition of "intermittent care."

This concludes my formal statement. I appreciate the opportunity to testify before the distinguished Members of this Subcommittee and look forward to working with you as you continue to work on developing a national long-term home care program.

Chairman STARK. Thank you very much.

First of all, Mr. Selstad, you wounded me. I thought I learned my progressive taxation in Wisconsin, my home State, which could only be slightly more progressive than the State of Minnesota.

In your concluding page, you suggest that a two percent tax, which I included in my plan, isn't progressive. Then you go on to say it would be more progressive to lift the Social Security wage cap. I don't see any difference between what I have done except that I am even more progressive in that I don't charge anything to those below $16,000 where Social Security starts at zero, and I do go all the way to infinity so somebody like Donald Trump would have to pay a small fortune.

Further, where you have a fixed benefit, the long-term care benefit, it would be a flat amount. By nature when you have an increasing cost premium for that benefit related to income, the net result is a regressive benefit and a progressive tax.

I think that is a pretty progressive system. It may not be as progressive as income tax brackets, but I will bet you it is close.

Are you an economist?

Mr. SELSTAD. No, sir.

Chairman STARK. Well, check that. I certainly went into that bill with the idea that I would dream up the most progressive financing scheme I could think of that would raise $60 billion a year. Unfortunately, inheritance tax only raises about $5 billion a year. We don't get anything. We create an awful lot of rich kids in this country, without it.

So I just wanted to ask you if you would reconsider that testimony. Because I think the net result of what I proposed is progressive, OK?

Ms. BÄBY. Yes, sir.

Chairman STARK. Paul, in your testimony you make reference to the beneficiaries who need but do not receive SNF care. What are the types of patients who need but do not receive SNF care because of the 3-day benefit? Who would get it if we repealed that rule?

Mr. WILLGING. Essentially, and I am neither an economist nor a physician, Mr. Chairman, which has forced me into being a lobbyist, I guess, I think it relates largely to those people who because of a legitimate recognition on the part of their physicians that the experience incurred doesn't require a hospitalization, whether it is a mild stroke victim or any other of the diagnoses you could come up with are not going to need the requirement for hospitalization, but could clearly benefit and meet all of the other legitimate coverage requirements for a SNF stay. I think that is one part of the equation.

The other part was very eloquently described in the testimony of the gentleman from the Alzheimer's Association, what clearly is transfer trauma experienced by a good number of residents who are transferred only for the sake, when there is not a legitimate reason, to put the individual in the hospital, though the services could be provided in the nursing facility itself.

Chairman STARK. Let me now inquire about what has been referred to as a ratchet effect. If I understand, the theory is that if we encourage Medicare providers—by becoming certified, we may very well pay them more for the same service before they were cer-

tified. I gather that was the implication in this question. You may view that as an unfair observation.

How do you respond to the suggestion that eliminating the 3-day rule will encourage use of certified providers wich will raise the costs, just because of the change of status?

Mr. WILLGING. As I understand the ratcheting effect it is quite simply the waiver of liability provisions. Right now, most facilities operate under the presumption, that is an intermediary presumption, that we are making accurate decisions based on the coverage manual. If we start moving patients arbitrarily and capriciously, we run the risk of losing the waiver, at which time HCFA reviews the claims of coverage liability before payment. This would cause major cash flow implications as we stop getting our funding within a 10- to 14-day period and start seeing funding come in after 60 or 90 days. So I think there is sufficient protection.

In addition to that, of course, prior to the provision in October 1990, the only way one could receive reimbursement for patients is if they were in a Medicare bed and now the law is quite clear that transfer simply for the sake of reimbursement is no longer allowable.

Chairman STARK. What do you think about the State of California suing HCFA after I just sued the State? I am confused by all these lawsuits.

Mr. WILLGING. Well, it is costing me a fortune, Mr. Chairman. We went out and intervened in the suit. I can't afford to intervene in many more lawsuits.

Chairman STARK. I can't afford the time to follow them all. I am wearing out my welcome with those law firms that will do pro bono work.

Mr. WILLGING. The American Health Care Association and the industry as a whole are in support of and have always been publicly in support of the Nursing Home Reform Act of 1987. We think it is a benefit to the quality of care we can provide our residents.

Chairman STARK. Well, I certainly want to state for the record that your association has always been in the forefront of trying to help us ensure quality facilities for all Americans, and I think in the end it serves us all well.

Ms. Bäby, you seem to be indicating that you want the home health care providers to also be the case managers. I have a daughter who, at great expense of time and money, just got a master's degree in social work, and I get a sense that you are trying to put her out of business. How do you deal with that? What do I tell my daughter?

Ms. BÄBY. I assure you, I am not trying to put your daughter out of business. In fact, I could offer her a position if she lived in Columbus, Ohio.

The issue of case management is very complicated. Frankly, what the National Association for Home Care has been trying to come to grips with is what is the appropriate level of case management and who or what parties are the most appropriate to provide such services.

Chairman STARK. Let me interrupt and just tell you my concern here. In a for-profit situation, I am concerned about conflict of interest, where the case manager would also be the one who would

stand to gain revenue from the decisions. Maybe you can address that? How do you ease my worries on that issue?

Ms. BÄBY. In a system which is totally without parameters, we would have the same concerns as you, sir. We feel that anyone in a position where they would have a direct monetary gain without the proper oversight would be inappropriate.

What we are trying to convey is that home health care agencies have something to offer in terms of care management. It is certainly within the purview of the Federal Government or whoever the payer may be to be the controller on the financial side.

What we would not like to see happen is a duplication of efforts by an outside party providing case management. Frankly, we have good and bad examples throughout our country right now in systems where the two sides have come together very well to the benefit of the patient.

There are other examples we have on an anecdotal basis that has not worked out so well. We would just want to proceed with caution and make sure both the financial side and the care side are well understood.

Chairman STARK. I risk being classified with those of my friends from the South who feel that the custom of tithing might eliminate the need for food stamps. I find that not a satisfactory answer. But on the other hand, in England, before they provide home health care, which is provided socially at no cost to anyone, they do an assessment which really takes into account what they feel the family members are capable of providing free.

I have been led to believe that the social worker would decide at least initially, the amount of time an elderly person's adult child could provide care for his or her parent given the proximity of the two I am not so sure that this is a skill that home health care providers are ready to decide, and I am not so sure it is a kind of decision Americans are willing to accept. Mr. Selstad is about to inform me that that is what a social HMO does, but I am not sure how we would legislate that.

I understand how a social HMO could build that, but how do you, in a specific sense of case management, assess what it takes a huge organization like Mr. Selstad's to do in a social HMO? Is it enough?

Ms. BÄBY. I am neither a registered nurse nor a social worker, so I am trying to look at this from a personal standpoint as objectively as I can. I think the skills of a case manager are very unique. They are not skills I think can automatically be bought by someone, no reference to your daughter, of course, who claims to be a medical social worker nor someone who claims to be a registered nurse.

Again, I have found on a personal basis, it much depends on the individual, their background, and their assessment abilities. Home care agencies today are not strictly geared in an acute care model. If I am to survive in our marketplace, I need to have professionals on board in both social work, and nursing, financial experts, and a whole line of other professionals. I would dare to say that some of the people who are employed by my staff would not be any different than those people who are employed within existing case management organizations.

Chairman STARK. Mr. Selstad, how do we do it in Minneapolis?

Mr. SELSTAD. Keeping in mind that the social HMO is at risk for the full range of benefits that are similar to what has been proposed in some of the comprehensive long-term care reform packages, we too——

Chairman STARK. Are you at risk on a per patient basis or in the aggregate?

Mr. SELSTAD. In the aggregate. As such, we have had to deal with the issue of case management as an add-on service, another layer of infrastructure that needs to be funded, or as part of the way in which we integrate the acute care and long-term care into more of a chronic care orientation that supports both.

In trying to deal with that situation, we have delegated to the nurses in the Medicare-certified home health programs that serve us, some of the case management authority, rather than duplicating that, and we kind of keep an eye on them, and Paul mentioned this whole issue of waiver of liability. I think that concept which Medicare is already using can be very constructive and will have clear financial incentives in a regular fee-for-service Medicare situation to keep the providers that are taking on some of this authority on their toes.

We do it flexibly in the social HMO. But we have had case managers in Medicare all along. We have had case managers in health care facilities all along. What we are talking about is trying to establish a chronic care focus that uses the input from both sides.

So while being at risk, Seniors Plus has not just added a whole level of case management, we have a lot of it conducted by the provider organizations.

Chairman STARK. Just out of curiosity, did your organization in Minneapolis evolve, or did you start it as an organization with all the pieces in place?

Mr. SELSTAD. The social HMO was set up with everything in place. With the assistance of Brandeis University and private foundations, we were able to do all the planning and development for the social HMOs and requested the waivers proposing how we would do everything intact.

Chairman STARK. So you started with all of the various services in place. You didn't start with a hospital health plan and add things to it?

Mr. SELSTAD. No, we started with the full-blown model.

Chairman STARK. If you could sometime, not for the record but just for my own enlightenment, could send me some literature on your social HMO with a modest number of words of more than two syllables, I would appreciate getting something on that to become a little more familiar with it.

Mr. WILLGING. I think in this case management issue, again, I would point to the Nursing Home Reform Act of 1987 which gives you a good set of guidelines of who should or should not, can or can not.

I think Congress, perhaps inadvertently, described the purpose and function of long-term care as well as I have ever seen it described, and that is to bring a resident to and maintain a resident at the highest level of well-being. Our association, too, sees the resident from that perspective.

Chairman STARK. I would like to have that problem. I figure it is a lot easier to go after abuses in the system than to get a system started. So that is a risk that I think the Chair certainly would be willing to take, and I suspect the committee would, if we can get the administration to let us get it started. Then we will depend on their hard-working, aggressive inspector general to ferret out the abusers and the fraud in the system, and get it running efficiently.

I want to thank the panel very much for participating, and I hope that as the year goes on, we can get a little bit done in the context of pay-as-you-go, and expand the benefits for our senior population. Thank you very much.

That concludes today's hearings.

Mr. WILLGING. Thank you, Mr. Chairman.

[Whereupon, at 4:10 p.m., the hearing adjourned.]

[Submissions for the record follow:]

TESTIMONY OF

AMERICAN ASSOCIATION FOR COUNSELING AND DEVELOPMENT

AMERICAN NURSES ASSOCIATION

AMERICAN PSYCHIATRIC ASSOCIATION

THE AMERICAN PSYCHOLOGICAL ASSOCIATION

ASSOCIATION FOR RETARDED CITIZENS OF THE UNITED STATES

INTERNATIONAL ASSOCIATION OF PSYCHOSOCIAL REHABILITATION SERVICES

THE MENTAL HEALTH LAW PROJECT

THE NATIONAL ALLIANCE FOR THE MENTALLY ILL

THE NATIONAL ASSOCIATION OF DEVELOPMENTAL DISABILITIES COUNCILS

NATIONAL ASSOCIATION OF PROTECTION AND ADVOCACY SYSTEMS

NATIONAL ASSOCIATION OF SOCIAL WORKERS

NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS

THE NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS

THE NATIONAL MENTAL HEALTH ASSOCIATION

submitted to

THE UNITED STATES HOUSE OF REPRESENTATIVES

WAYS AND MEANS SUBCOMMITTEE ON HEALTH

on the subject of

Long-Term Care Eligibility

March 4, 1991

The Honorable Pete Stark, Chair

This testimony reflects the position of the following organizations regarding eligibility for long term care services. These organizations may also submit separate statements addressing additional issues.

American Association for Counseling and Development
American Nurses Association
American Psychiatric Association
American Psychological Association
Association for Retarded Citizens of the United States
International Association of Psychosocial Rehabilitation Services
Mental Health Law Project
National Alliance for the Mentally Ill
National Association of Developmental Disabilities Councils
National Association of Protection and Advocacy Systems
National Association of Social Workers
National Association of State Mental Health Program Directors
National Council of Community Mental Health Centers
National Mental Health Association

The aforementioned organizations wish to commend the Chairman for his leadership in the ongoing effort to improve our country's system of health care delivery. The introduction of H.R. 651 is an important step in addressing the long-term care needs of American families, providing services not only for the elderly but for those under 65 as well.

Long-term care legislation should provide universal coverage so that functionally disabled persons of all ages will be eligible to receive services. People with mental disabilities as well as people with physical disabilities may need assistance to function and handle the demands of daily living. As with people who are elderly, the provision of long-term care services needs to be individualized, some people requiring life-long care on a regular basis and others requiring services for shorter durations or intermittently. For example, people with mental retardation may need habilitation, training and other services to improve their functioning in instrumental activities of daily living such as meal preparation and managing finances. It is critical that Congress focus on the need for such services, rather than the cause of the individual's functional impairment.

We believe the intent of H.R. 651 is to provide universal coverage for long-term care services, therefore we are concerned that the bill is not in fact inclusive of all those who require services. In H.R. 651, Section 2102, (c)(1)(B), the eligibility criteria is restricted only to those persons with cognitive impairments, excluding those with with other mental impairments. However, section (c)(3)(B) of H.R. 651 states that a comprehensive needs assessment must include "an assessment of the type of a person's impairment and functional status, both physical and mental", and section (d)(3)(B)(ii)II states that a review and revision of individual care plans must occur "promptly after a significant change in the individual's physical or mental condition."

We believe the eligibility criteria should agree with this language, specifying that persons eligible for long-term care services will include those persons:

(c)(1)(B) having a similar level of disability due to cognitive or other mental impairments, such that without supervision the individual would be unable to care for himself or herself or would be a danger to himself or herself.

Equitable treatment of persons who require long-term care services requires that eligibility be based, not on the cause of a functional impairment, but rather, on appropriate measures of functional dependence or impairment. The cause of the functional dependence or impairment is relevant only when determining appropriate treatment and service needs.

Finally, we would suggest changing the term "Chronically Ill Individual" to define eligible persons to more accurately reflect the numerous determinants of functional status. While functional dependence can result from a debilitating, chronic illness, there are many persons with a chronic illness who do not require long-term care, and many persons who are severely functionally impaired who do not have a chronic illness, e.g. a person with quadriplegia. We suggest using instead the term "Individual with a Chronic Illness or Disability".

We strongly urge the Subcommittee to address the needs of all people with disabilities who are functionally dependent. We are greatly concerned that physical and mental impairments not be accorded different treatment in legislative long-term care proposals.

We thank you for this opportunity to present our views.

Statement
of
The American Occupational Therapy Association, Inc. (AOTA)
on
Improvements to the Medicare Home Health Program

Mr. Chairman:

The American Occupational Therapy Association is pleased to have the opportunity to submit this statement on improvements to the Medicare home health program in conjunction with the Subcommittee hearings held on March 4, 1991.

The Association represents the professional interests of some 43,000 occupational therapists, occupational therapy assistants and students of occupational therapy. Members of our profession provide services to Medicare beneficiaries in hospital inpatient and outpatient settings, physician offices, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, hospices, rehabilitation agencies and clinics,and through home health agencies. In addition, Medicare certified occupational therapists in independent practice render outpatient occupational therapy services to beneficiaries.

We wish to bring to the attention of members of the Subcommittee a problem in the Medicare home health benefit as it is currently structured. In order to qualify for services, a beneficiary must be under the care of a physician who certifies that the individual is confined to the home and requires intermittent skilled nursing care, physical therapy or speech therapy. If the beneficiary requires one of these qualifying services, then occupational therapy services may also be provided. In addition, occupational therapy services may continue to be provided after the individual's need for qualifying services has ended.

Occupational therapy personnel and the beneficiaries they serve are confused and frustrated by a Medicare policy that allows beneficiaries to receive medically necessary occupational therapy services under the home health benefit only if they are in need of another service. Requiring a multitude of services when a person needs only one is neither logical nor cost effective, and we urge the Subcommittee to consider legislative modifications that would establish occupational therapy as the fourth qualifying service under the Medicare home health benefit.

Occupational therapy is an important part of the home health care provided to many Medicare beneficiaries. It is especially necessary for individuals who are victims of strokes, heart attacks, diabetes, multiple sclerosis or spinal cord injury, who are disabled by severe arthritis, or who have suffered physical injury as a result of a fall or some other accident.

Occupational therapy focuses on increasing the patient's functional level. This service often plays a critical role in ensuring the patient's full recovery, the prevention of further disability, and a successful readjustment to the home and community environment. The occupational

therapist will establish a treatment program designed to increase the patient's level of physical function. The therapist will also teach the patient, and those family members or others who will care for the patient, compensatory techniques which permit the patient to function more independently with feeding, dressing, and personal hygiene activities. The therapist will also make splints and self-help devices which either protect against joint deterioration, e.g. with an arthritic patient, or make the individual more independent, e.g. by providing stability of the wrist joint which will allow a person with severe wrist deterioration to use their remaining hand function. Finally, the therapist will recommend changes in the physical environment of the home to promote increased patient independence under the safest conditions possible.

In many instances only occupational therapy is required to meet the medical needs of homebound beneficiaries. The current restriction on occupational therapy services undermines the principle of providing quality health care at the lowest possible cost to the Medicare program. Specific patient conditions where only occupational therapy might be needed include the following:

- The arthritic patient who has been ambulatory and functioning independently in her home calls her physician because she is no longer able to walk safely and has fallen several times. The physician determines that she has decreased knee and ankle motion bilaterally due to accelerated osteoarthritic changes. The physician orders a home health occupational therapist to design and fabricate night resting splints to increase knee and ankle motion and prevent further deformity. Without these splints, the joints will permanently lose range of motion, and the patient may never walk again. The physician's alternative to occupational therapy in the home is admitting the patient to a hospital or transporting her by ambulance to a community facility or the out-patient department of a hospital.

- The diabetic wheelchair-bound patient with bilateral above-knee amputation, partial blindness, and decreased sensation in her hands due to diabetic neuropathy has been discharged from the hospital soon after she was independent in wheelchair transfer techniques. She needs the continued services of an occupational therapist to teach her an acute awareness of her sensory deficits and compensatory techniques to overcome her partial blindness and poor hand sensation. Without the occupational therapy program, complications such as accidental burns in the kitchen and decubiti can easily occur.

- The homebound patient with chronic lung disease and subsequent weakness, decreased endurance, and a continuous need for oxygen has difficulty performing daily functional activities. She is unable to pace her activities with her limited breathing capacity, and her physician has ordered occupational therapy to see if an energy conservation program will allow the patient to perform the

necessary daily activities to remain at home and avoid nursing home placement.

- The patient with a long history of multiple sclerosis is experiencing increased difficulty with coordination due to spasticity and is no longer able to feed herself. She needs an occupational therapist to decide whether adaptive equipment would allow her to regain independence. Only the occupational therapist is skilled in assessing and providing this type of equipment, and no other services is necessary.

In all of these instances occupational therapy would be provided in accord with existing Medicare coverage criteria as specified in the intermediary manual for home health agencies. These criteria require that occupational therapy be prescribed by a physician, be performed by a qualified occupational therapist or assistant, and be reasonable and necessary for the treatment of the individual's illness or injury. Occupational therapy is considered reasonable and necessary when "an expectation exists that the therapy will result in a significant practical improvement in the individual's level of functioning within a reasonable period of time."

Cost considerations are clearly essential in assessing any proposal to revise existing coverage of services under the Medicare program. At the request of Senator George J. Mitchell (D-ME), the Congressional Budget Office (CBO) has prepared an estimate of the potential cost of allowing individuals to qualify for Medicare home health services on the basis of a need for occupational therapy services. The CBO estimate project costs directly attributable to expanded utilization of occupational therapy services to be $16.8 million. The CBO estimate also assumes, however, that beneficiaries qualifying for home health services through their need for occupational therapy will also require the services of a home health aide at least as often as they need occupational therapy. As a consequence, the estimate assumes an additional $31.2 million in home health aide cost.

We believe, however, that the CBO assumptions overstate the costs because they fail to take into account several factors. First, the CBO assumption that home health aide services would be provided as frequently as occupational therapy services substantially overstates utilization patterns based upon reports from our membership and based upon a random review of Medicare intermediary claims data. Secondly, CBO does not take into account cost savings that would accrue to the program by eliminating instances that likely occur under current law where qualifying services of questionable need are prescribed in order to meet the beneficiary's need for occupational therapy. Finally, it fails to assess savings resulting from the avoidance of recurring disability with its accompanying need for a return to more costly care in a hospital or nursing home setting when beneficiaries are unable to receive covered occupational therapy under the existing home health benefit. In summary, it is our view that the net cost increase to the program would be minimal in light of the above stated reasons and in view of the fact that it would not affect large numbers of beneficiaries. However, for those beneficiaries who would be affected, their need is critical.

We believe that adding occupational therapy as a qualifying home health service is a reasonable and much needed improvement which will significantly strengthen the home health benefit and the Medicare program. We urge the Subcommittee to view this proposal favorably and consider incorporating it into any Medicare legislative initiative being contemplated this year.

TESTIMONY OF U.S. REP. FRANK ANNUNZIO (11TH DIST-ILL)
BEFORE THE SUBCOMMITTEE ON HEALTH
HOUSE COMMITTEE ON WAYS AND MEANS
ON H.R. 651
MONDAY, MARCH 4, 1991

MR. CHAIRMAN: I thank you for holding this hearing so we can address the need for increased access to long-term care for our senior citizens.

Recent research indicates that nearly 9 million seniors are now in need of long-term care, either in their homes or in nursing homes.

I'm especially concerned about home-based care because it can enable seniors to continue living in their homes, where many have spent the majority of their adult lives.

The average price for nursing home care is now nearly $36,000 per year, and regrettably many American families today can't afford these services. Home-based care can cost up to $14,000 per year, or more, for seniors with serious health problems. It is less costly than nursing home care, but at the same time, far preferable for most senior citizens because it permits them to remain in their own homes.

Today thousands of seniors with moderate incomes watch helplessly as their life savings rapidly dwindle in order to pay for nursing-home care or home-based care. Most private insurance programs are either too expensive or too limited to help seniors pay these costs.

You will recall that the Pepper Commission determined in 1988 that nearly half of the $43 billion spent on nursing home care was paid out of the pockets of our citizens.

Like blood pouring from a gaping wound, America's long-term care crisis is draining the financial resources of our seniors. We in the Congress must work together to forge a consensus for dealing with this problem.

The Congress is now considering several bills to address this issue. Among these is H.R. 651, which I have cosponsored.

This bill, known as the Mediplan Long-Term Care Act of 1991, was introduced by Congressman Fortney "Pete" Stark of California, the Chairman of this Subcommittee on Health, and it would expand Medicare benefits so that all seniors have access to nursing home or home-care services.

I believe H.R. 651 is a positive, first step toward resolving the problem of long-term care for our seniors. I compliment Mr. Stark for offering this proposal to our debate on this vital issue.

Statement of Linda Jenckes, Vice President, Federal Affairs,
Health Insurance Association of America

The Health Insurance Association of America represents 300 private health insurance companies which provide health insurance for 95 million Americans.

The current system for financing long-term care is clearly unacceptable. Instead of pooling risks, it places each household on its own and Medicaid becomes the payor of last resort when household resources are depleted. This system, combining out-of-pocket outlays and welfare, features remediation and relief when prevention and planning would be preferable.

HIAA believes the government should target its limited resources to assist those who can least afford such protection. Private insurance products are not designed for, nor do they lend themselves as, financing vehicles for people who are already quite old, disabled, or poor. Providing care for this population should be the objective of the public sector, and reforms are needed to improve the government's ability to act as a responsible safety net for those who must rely on it.

Embarking on a highly prescriptive national long-term care program would fail to build on the achievements already reached by the private sector. The size of the federal deficit and the national debt are staggering reminders that federal funds should be carefully targeted.

Background

While there is increasing public awareness that long-term care is not a benefit of Medicare nor of Medicare supplemental insurance policies, the many facets of paying for prolonged health and custodial services in later years have yet to be solved for the majority of our citizens. The statistics speak loud and clear:

- The lifetime risk of individuals over 65 entering a nursing home is at around 40 percent; it is almost 50 percent for women.

- When an elderly person spends more than $2,000 per year out-of-pocket on health care, what has been described as "catastrophic" health care costs, 80 percent of that is likely to go to nursing home care.

- New estimates peg the average yearly cost of nursing home care at $25-30,000.

- About 9 million people will require long-term care by the turn of the century. Currently about 70 percent of them receive care in their homes and communities from family members and friends. Another 30 percent need some type of paid assistance, and at one time or another 40 percent of all elderly will spend time in a nursing home.

- Providing long-term care is more than a matter of financing it. Long-term care delivery systems are mostly uncoordinated and a mystery to most individuals needing to access them. In many cases where a nursing home placement is not desirable, it is often the only choice when other forms of long-term care assistance such as home health aides, adult day care, respite help simply do not exist.

Developments in Long-Term Care Insurance

A national survey conducted in 1989 by the University of Maryland's Center on Aging found surprising willingness by the public to purchase a long-term care plan if it met their long-term nursing home and home health care needs. Overall, over one-half of those surveyed indicated they would pay $100 a month for such a plan. At age 65 this $100 would buy five years worth of nursing home coverage at $36,000 a year or 10 years of at home care at around $18,000 a year. In addition, two-thirds of full-

time workers said they would be more willing to purchase a policy if it were offered by their employer, even if they, themselves, paid all or some of the premium.

The long-term care insurance market is developing rapidly, as evidenced by the number of companies developing products, the number of individuals covered and the variety of products being developed. There are now over 130 companies selling a long-term care product and almost all of this growth is since 1985. As of June 1990 more than 1.65 million long-term care policies had been purchased.

More importantly, the products themselves are changing. The earlier products tended to be more limited. For instance, they covered only stays in a nursing home and then only following a hospital stay. But virtually all the newer products offer coverage of nursing home and home health care, without institutional gatekeeping mechanisms like prior hospitalizations. Instead, benefits are often triggered based on the need for assistance in personal care functions such as bathing, walking, and dressing. In addition, they provide inflation protection against future long-term care costs. We will see a continued trend toward more comprehensive and liberal benefit provisions as the market place becomes more competitive.

The recent introduction of employer-sponsored plans is particularly promising. These employee pay-all plans offer the opportunity to reach a large number of people efficiently during their working years when premiums are more affordable. Coverage in the workplace offers the additional advantage of employers selecting the best plan at more affordable rates for their employees.

We believe that it is the employer market where significant growth will continue to occur. As of the beginning of 1990, only nine insurers had sold coverage to employer-sponsored groups, and only 3 percent of all persons were covered under such arrangements. The number of employers offering this coverage however has grown exponentially from two employers in 1987, to five employers in 1988, to 47 in 1989 with another 64 expecting to enroll participants in 1990. By mid-1990, a total of 153 employers offered or were about to offer long-term care insurance even without any tax clarifications.

In mid-1990, HIAA conducted a survey of the employer market and found that of the 105 plans with enrollment experience, almost 700,000 employees were offered a long-term care insurance plan. Most of the plans allowed employee's spouses, retirees and their spouses and the parents and parents-in-law of the employees to obtain coverage. The average age of active employees electing coverage is 43 years.

As of June 1990, about 79,500 persons were enrolled in employer-sponsored long-term care plans. About 60 percent of the enrollees were active employees and their spouses. The other 40 percent were retirees and their spouses, parents and parents in-law. This is an area where tax clarification and increased consumer education will lead to even further coverage.

<u>Appropriate Public Financing Role</u>

According to the Employee Benefit Research Institute, an estimated $56 billion was spent on all long-term care services in 1987. Over half, $30.6 billion, was paid by the public sector. Assuming no change in our current financing system, the Congressional Budget Office has estimated that current spending could increase between 50 and 200 percent by the year 2000.

Given today's fiscal realities and competing national priorities, we cannot expect the public sector to take on such an enormous and unwieldy financial responsibility. Instead, HIAA believes

that public policy should be targeted toward finding ways to more effectively use the private resources already being spent for this care, thereby reducing future public long term care expenditures. Those who can afford to protect themselves should be encouraged to do so.

It is not the role of government to protect and preserve assets or income levels of individual citizens against the various contingencies of life. In general, it is the responsibility of individuals to plan for their own needs to the maximum extent possible. It is the role of government to provide sensitive and responsive support to those who face needs beyond their individual financial capacity to deal with them.

Educating the Public

The need for better consumer education is the responsibility of both the private and public sectors. It is virtually impossible to sell a product to someone who already believes they have it. However, this is where we find ourselves with long-term care insurance. Education should begin early, so that working age people can plan for their potential long-term care needs while they have the income to do so.

State Regulatory Environment

Long-term care insurance is a new product that continues to evolve. Insurers need a state regulatory environment which is sufficiently flexible to allow for the development of new and different products but is equally effective in protecting consumers. In December 1986, the National Association of Insurance Commissioners (NAIC) first adopted model legislation that successfully balances these two objectives. Since then, the model statute has been modified several times to better meet consumer need.

To date 41 states have passed legislation or adopted regulation based on the Model Act or Regulation. Additionally six states have some other form of long-term care insurance regulation. In the remaining three states the product is not unregulated, but falls under laws of general applicability for health insurance. We are encouraged at the speed with which states have acted to govern this new product. As an industry, we must minimize the potential for consumer abuses if we are to sustain a viable market.

In addition, the HIAA Board of Directors has approved a consumer protection proposal developed by its members which includes recommendations in both the legislative and regulatory areas on such issues as marketing, education and product design. Effective regulation of long-term care insurance and meaningful consumer protection is in the interest of both consumers and the health insurance industry. Any bad agent or company practices that may exist must be eradicated.

HIAA PROPOSAL FOR FINANCING LONG-TERM CARE

On May 6, 1990, the HIAA Board of Directors adopted a comprehensive proposal for financing long-term care which utilizes the inherent strengths of both the private and public sectors in a more efficient, focused and equitable manner than the essentially unstructured system in place today. HIAA has seen that given the knowledge and opportunity, the vast majority of Americans would prefer to make provision for their own long-term care needs through private savings mechanisms, especially those involving risk pooling. By thoughtful, competitive and broad-based expansion of such arrangements, the proportion of long-term care financed by the private sector will gradually increase and will be distributed among individuals in a more rational fashion than it is today.

1. PRIVATE INSURANCE IS AFFORDABLE FOR A LARGE NUMBER OF AMERICANS

HIAA recognizes that it is people with adequate resources who will pay, either directly or indirectly, for their own care and the care of those who cannot afford to provide for themselves.

HIAA believes that, to the extent possible, persons of all ages should be encouraged to pay for their own care. Private insurance, through the lower average cost of risk sharing, gives more people the opportunity to use their own resources to do so. According to the estimates developed by LifePlans, Inc. and Boston University, about 40 percent of the current elderly could afford to purchase private long-term care insurance and affordability estimates are as high as 48 percent if only those aged 65 to 79 are considered.

These findings are supported in separate analysis conducted for AMEX Life Assurance Company using the Brookings/ICF long-term care financing model. This analysis found as many as two-thirds of the non-Medicaid eligible elderly aged 65-79 could afford their company's long-term care insurance policy if health expenses and long-term care premiums were less than 10 percent of available income. If more than 10 percent of personal resources were considered, estimates were even higher.

For the nonelderly, LifePlans estimates that between 50 and 70 percent of those in the workforce, as well as a high proportion of nonworking spouses, represents the potential long-term care insurance market. Estimates were based on current pension and health insurance coverage. Clarification of long-term care insurance as health insurance in the federal tax code could push this figure toward the upper bound estimate. It is also important to note that affordability will become less of a problem at older ages as more persons purchase policies while they are working and are younger. Therefore, HIAA supports the following long-term care tax clarifications:

- Employer sponsors of long-term care plans may take tax deductions for actuarial appropriate contributions toward premiums or trust funds and for interest accrued on any such funds to the extent that it is irrevocably committed to the provision of long-term care benefits. Such contributions on behalf of employees and their dependents should not be considered taxable income to employees.

- Long-term care options may be included as tax preferred employee benefits in employer programs, including cafeteria plans.

- For the purpose of determining the tax treatment of benefits received by individuals under long-term care insurance plans, those plans should be considered health insurance.

- Providers of long-term care insurance may take tax deductions for actuarial appropriate additions to reserves. Although this was clarified as such in a March 1989 IRS administrative revenue ruling, HIAA supports legislative language codifying this decision.

2. PUBLIC EXPENDITURES SHOULD BE TARGETED TO CRITICAL NEEDS

HIAA also recognizes that the private sector cannot realistically meet the entire need. There is a significant need for public sector involvement. This is true especially for the current generation of elders, who have not had the time, product availability or financial resources to provide effectively for themselves. HIAA believes that government should target its assistance to those who are in greatest need.

We believe this position is consistent with the views of the American public. In the University of Maryland poll cited earlier, 60 percent of respondents indicated that they would favor a government program that targeted its assistance for those in need rather than one providing coverage for everyone. For the 35 percent favoring a public program for all, willingness to pay estimated payroll taxes was highest among those over 65 and those with incomes below $20,000 and lowest among those under 49 and those with incomes above $50,000. In other words, persons least likely to pay for the program's benefits were most in favor of its adoption.

Through targeted public assistance the government could minimize its spending and maximize coverage for those most in need. However, eligibility for current public assistance, i.e., Medicaid, is rather harsh -- most single persons are required to spend all their liquid assets, except for $2,000, toward their care, providing minimal resources to return to the community or to leave for their estate.

Analysis conducted by LifePlans indicates that allowing Medicaid eligibles to keep $8,000 in assets would increase current Medicaid spending 11.2 percent ($2 billion) while increasing the asset threshold to $12,000 would cost Medicaid an additional 18 percent or $3.2 billion in federal dollars. The cost of allowing persons to retain higher levels of assets and still qualify for Medicaid would be marginal and the benefits would accrue primarily to persons with incomes of $15,000 or less.

HIAA also supports an increase in the nursing home personal needs allowance, which is currently $30 a month, although many states allow persons to retain $50 a month. HIAA supports the Pepper Commission recommendation which proposed that residents be allowed to keep $100 of their monthly income for their own use. LifePlans estimates that increasing the personal needs allowance to $100 a month (from a base of $50/month), would cost an additional $1.01 billion.

HIAA also advocates that Medicaid's institutional bias toward nursing home use be eliminated to encourage low and moderate income elderly to receive community-based long-term care services. Because Medicaid currently covers so little home care, most of these expenditures would be new. To be eligible for care, we propose using income eligibility criteria developed from the Medicaid long-term care waiver program to cover persons in the community with incomes up to 300 percent of the Supplemental Security Income limit (which varies for single and married persons). In addition, we propose that single persons be allowed to retain nonhousing assets valued up to $12,000 and that married couples be permitted to retain up to $24,000 in nonhousing assets.

According to estimates developed by Lewin-ICF, the cost of a public program covering elderly people who need active assistance in three out of five activities of daily living (ADLs), and who meet the income and assets criteria above, is an additional $4 billion annually. This is a substantial increase over current state and federal spending of about $2.4 billion for home and community-based care. This estimate does not include serving the nonelderly or the cost of providing care to persons whose cognitive impairments require supervision in performing ADLs. Although an additional $4 billion is a significant increase in federal spending, it is considerably less than the recommendation of the Pepper Commission which proposed a $24 billion program to provide home care to severely disabled persons of all ages and regardless of their ability to pay for their own care.

HIAA does, however, support the Pepper Commission recommendation that Medicaid form the basis for this new government program, but that this new program no longer be part of the Medicaid program.

Such a reorganization would assist the states in administering the program, facilitate the development of uniform coverage criteria, remove long-term care from competing acute care coverage needs, and alter the current welfare perception of the program's long-term care benefits. Additional dollars necessary to fund the program should be contributed by the federal government.

A portion of this new program could be funded through estate recoveries of recipients after their death and the death of a surviving spouse. Although data are generally lacking, 1989 General Accounting Office (GAO) report estimated that as much as two-thirds of the amount spent for nursing home care for Medicaid recipients who owned a home could be recovered from their estates or the estates of their spouses in the eight states studied. GAO recommended to the Congress that they consider making mandatory the establishment of state programs to recover the cost of Medicaid assistance provided to nursing home residents either from their estates or the estates of their surviving spouses.

Additional revenues could also be generated from strengthening the transfer of assets rules so that individuals could not give away property in order to qualify for Medicaid. Again, although data are generally lacking in this area, a 1989 study by the Office of the Inspector General of HHS found that people who were initially denied, but subsequently approved, for Medicaid nursing home coverage in Washington state possessed $27.5 million in assets at time of denial. At the time of Medicaid approval, it was determined that 70 percent of this money had been sheltered -- 59 percent was transferred to a spouse and 11 percent was transferred to adult children. Another 11 percent was considered exempt from Medicaid eligibility rules and only 8 percent was used to pay for long-term care. (The disposition of the remaining 11 percent was uncertain.)

3. GOVERNMENT ROLE IN EDUCATION IS ESSENTIAL

HIAA believes that the public will support neither private nor public sector efforts to address the long-term care financing problem unless they understand that it is, in fact, a problem. Over the last several years, the insurance industry has made an extensive effort to inform the public about long-term care and its potential costs. Since 1987, when the HIAA long-term care consumer guide was first published, over one million copies have been distributed.

A primary conclusion of the LifePlans analysis is that the public's lack of knowledge about long-term care and the federal government's lack of a clearly articulated role in this area is inhibiting growth of the private market. To address this problem, HIAA believes that the federal government must take a stronger position in educating the public about limited government coverage for long-term care. The elderly need to understand the limitations of Medicare and Medicaid. Those under 65 need to understand how planning for potential long-term care expenses fits into their overall retirement needs.

In both cases, the goal of public and private sector education efforts is to allow consumers to make informed choices, which may or may not include the purchase of a long-term care insurance policy. If insurance is purchased, it is clearly in the industry's and consumer's best interest for individuals to clearly understand what they have bought.

The government could play several different roles in consumer education including the development of consumer guides on long-term care and long-term care insurance to be developed jointly by representatives from consumer, federal, state, provider, insurance and seniors' organizations; distributing these guides to all new Medicare beneficiaries, the Consumer Information Center and local referral agencies such as the Area Agencies on

Aging; and conducting public radio and television announcements which inform the public about long-term care.

A more active government role was proposed by Senator Pryor as the "Health Insurance Counseling and Assistance Act of 1990" subsequently adopted as part of the OBRA 1990, which gives states the ability to establish programs, using volunteers, to provide objective health insurance counseling to senior citizens. HIAA supports the objectives of the bill although we have some questions and concerns about the program's implementation and structure.

Another approach for government education could be a nominal tax subsidy for the purchase of long-term care insurance. If targeted for the current elderly and phased out for purchases after a short period of time, it would benefit a group who did not have the opportunity to purchase such coverage when they were younger and the premiums were lower and as a result, now face the greatest affordability problems because of their age.

This recommendation was first made in former DHHS Secretary Bowen's 1986 report on catastrophic illness which called for a $100 credit toward the purchase of long-term care insurance. Although a nominal amount, the report concluded that the educational effects of such a credit far outweighed its monetary value by educating consumers about an important issue and as a result, would help to change attitudes as well.

The LifePlans analysis indicates that a 10 percent premium subsidy, which on average approximates a $100 credit, would cost about $174 million. Although this analysis does not show a significant increase in the private market as a result of the subsidy, LifePlans' concludes that their financing model cannot capture the psychological and educational effects a government-sponsored premium subsidy could create. Therefore, the benefits of this approach in conjunction with a direct educational campaign should be considered.

SOCIAL INSURANCE IS COSTLY AND UNWARRANTED

As stated above, HIAA believes that social insurance proposals for long-term care are prohibitively costly and unwarranted given the potential of the private market. Moreover, the LifePlans analysis of social insurance proposals indicates that social programs are an ineffective use of public dollars. The marginal benefits from such programs assist many elderly who need it least -- those with higher income and asset levels. They do very little to help the elderly with more modest resources, as compared to current public policy. This finding remains true regardless of whether the social insurance program pays for back-end catastrophic protection or only covers the first several months of care.

For example, a social insurance back-end program which provides a lifetime home care benefit (with copayments and deductibles) and covers nursing home care after a 2-year deductible, is estimated to cost an additional $15.3 billion over current government spending. Over one-third of these expenditures would benefit those elderly with annual incomes of $30,000 or more. Another 40 percent would benefit those with incomes between $15,000 and $30,000. Only 25 percent of the new benefits accrue to lower and moderate income elderly because Medicaid is already available to them.

A social insurance front-end program which provides total coverage for a lifetime home care benefit and covers the first year of nursing home care is estimated to cost an additional $19.7 billion over current government spending. About one-third of these expenditures would benefit those elderly with annual incomes of $30,000 or more. Another one-third would benefit those with incomes between $15,000 and $30,000. Like the

approach modeled above, few benefits would accrue to lower and moderate income elderly because this proposal mostly substitutes for current Medicaid coverage. However, slightly more lower income elderly benefit from this approach over the one above because of the more comprehensive home care benefit.

PRIORITIES FOR ADDITIONAL PUBLIC SPENDING

Rather than spend tax dollars to provide long-term care to those who can afford to protect themselves, HIAA believes it is a higher priority to devote those public expenditures toward ensuring the delivery of quality long-term care services. Reimbursement policy under the targeted public program must be adequate to ensure quality care and deter cost-shifting to private paying patients. In addition, quality enforcement programs must be adequately funded and supported.

Government spending should also be targeted on research affecting long-term care use and costs, as recommended by the Pepper Commission, and support of demonstrations involving public-private financing partnerships, such as those proposed by the eight states participating in the Robert Wood Johnson Foundation program. More resources are needed in basic and applied biomedical aging research to facilitate the management of chronic disease and disability. Treatments which ameliorate or control conditions such as Alzheimer's disease, incontinence, and osteoporosis will greatly enhance the quality of an older person's life and significantly reduce the need for costly long-term care services. The federal government must also continue its important function of organizing and collecting data through national surveys and share this information in a useful and timely manner. Financial support of such research and demonstration efforts are fairly minimal when compared to the tremendous benefits they will reap over the long-range.

SUMMARY OF HIAA POSITION

As set forth in the analysis and discussion above, HIAA believes the role of the public sector in financing long-term care is:

- Clarifying the tax status of private long-term care insurance to help stimulate the development of the private market,
- Targeting its direct long-term care assistance to those who are in greatest financial need,
- Assisting the private sector in educating the public about long-term care through a variety of mechanisms,
- Ensuring the delivery of quality long-term care services, and
- Supporting research and demonstrations related to the need for long-term care services and public-private partnerships in paying for care.

The flexibility of private insurance offers families and the elderly the preferred approach to prefunding long-term care for many Americans. And, over time, we believe private insurance will give millions of people an opportunity to be financially independent throughout their retirement years.

HIAA believes it would be a mistake to minimize the role of private insurance in designing a comprehensive national policy for long-term care. Instead, the public and private sectors must combine their efforts and knowledge to create a solution that will benefit most Americans today and in the future. This investment will pay off many times over as you and I grow older

and it will help us avoid placing an insupportable tax burden on our children.

Thank you for the opportunity to provide our comments and we look forward to working with you to provide further assistance in this area.

[ATTACHMENTS TO THIS STATEMENT ARE BEING RETAINED IN THE COMMITTEE FILES.]

Stewart Bainum, Jr.
Chairman

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Statement of
Stewart Bainum, Jr., Chairman of the Board
on
Long Term Care Coverage and Financing
to the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
March 4, 1991

Manor Care appreciates the opportunity to present our perspective on the challenges facing you in meeting the skilled nursing care needs of Medicare beneficiaries. We are dedicated to providing high quality service to each of our 20,000 residents. We are especially proud of our performance record as a provider of approximately 700,000 Medicare patient days during our last business year.

* Manor Care focuses on providing highly skilled nursing and rehabilitative services. This service is enhanced by an increasing variety of specialized treatment units, notably 40 Alzheimer's units and 6 wings for sub-acute rehabilitation.

* Our goal is for our 166 nursing centers to be the most desirable in their communities. A continual process of construction, renovation, and maintenance helps us preserve our market position.

* We employ over 18,000 people, with emphasis on the training and development of both new and existing employees. Many of our standards and procedures, in such areas as quality assurance, staff development, and resident assessment, lead the industry.

* As a care provider in 28 states, we have experience with diverse methods of reimbursement under Medicaid, some of which are more innovative than Medicare and others create a more adverse situation.

We applaud your oversight and legislative interest in improving the methods by which Medicare purchases services for its beneficiaries. You know the demographics of the aging population and their needs for nursing home and other long term care. What we can offer you is a front line perspective on the reality and potential of long term caregiving, particularly under the Medicare program.

Although this statement will focus on Medicare improvements, it is important at the outset to emphasize that the critical issues of long term care go far beyond the scope of Medicare benefits today. Even in terms of national nursing home expenditures, Medicare's proportion was less in 1989, under the catastrophic coverage, than in the early years of the program.

Another critical issue is quality of care reform. This is the first Congressional hearing on nursing home issues since the implementation of the new and expanded requirements under OBRA 1987, such as nurse aide training and comprehensive resident assessment. Manor Care strongly supported the 1987 reforms, but their implementation has created many changes for government regulators and providers.

Private Financing for Quality and Growth

The inescapable reality is that the needs of long term care cannot be completely answered by federalizing patient care financing. The critical role of private financing in a number of areas needs to be both understood and encouraged.

a. Delivering Quality Care Today

First, private financing is needed to deliver high quality care and accommodations to all residents. This consideration is particularly important in the many states in which Medicaid reimbursement is insufficient to provide high quality care. Since Medicaid pays almost half the costs of nursing care, its shortfalls hold down the performance of the entire industry. To provide higher level care, we must subsidize Medicaid patient care by attracting a large number of private pay patients.

While Medicare reimbursements are higher, we must similarly subsidize Medicare patients with private patient fees in some areas. One reason is that Medicare procedures for allocating costs result in an averaging of all patient costs. Thus the generally higher costs for Medicare patient care, especially for "heavy care", are not fully reimbursed.

b. Meeting Tomorrow's Demand for LTC

Private financing is necessary to increase the supply of beds available to serve the growing elderly population. The "age wave" is about to submerge the nation's structural capacity to provide long term care. Bed shortages already exist in most localities, especially for preferred facilities.

Unlike hospitals, where there is overcapacity, the U.S. needs a major expansion of nursing home capacity. To meet the nursing home care projections of the Pepper Commission cost about $46

billion by the year 2000 for construction of over 1.1 million new beds, or 312 beds per day. Also large, but harder to estimate, are capital requirements for renovating or replacing old facilities.

It is highly unlikely that these funds will be provided by the Federal Government. We must therefore turn to private sources of financing. As you know, the private capital market is highly competitive and sensitive to investment risk. At present, the investment are low for the perceived degree of risk, stymieing the flow of new funds into the industry. For instance, the Investor's Daily index of stock investments in the nursing home sector is still below its level at the beginning of 1984.

One of the ways the Federal Government plays a key role in the industry's ability to attract private investment is as a payor under Medicare and Medicaid. These payors represent more than half the revenues of the nursing home industry. Obviously, if payment levels from these programs do not provide sufficient returns, it is very difficult for fees from private pay patients to make up the deficit and then provide an appropriate total return on private sector capital.

President Bush's continuing proposal to end any return on equity for nursing home investments under Medicare sends exactly the wrong signal. The cost of capital is just as real a cost as a nurse's salary. The Medicare rate of return is comparable to a U.S. Treasury 30 year bond yield, now about 8.3 percent. This rate is already insufficient to attract new private capital to nursing care, considering financial risk and competing investment opportunities. Medicare's rate of return is roughly half the equity return received by investing in the S&P 500, but Medicare's half rate is better than none. Its total repeal, however, would be clearly anti-growth and perversely encourage more expensive and riskier debt leveraging alternatives.

c. Tax Policies

In fact, the other areas of jurisdiction of the Ways and Means Committee may provide greater opportunities to shape long term care. Most obvious are tax policies for personal financing arrangements and nursing facility construction.

Prospective Payment

Manor Care supports the concept of a Medicare prospective payment plan covering skilled nursing facilities based on patient needs. We are, however, increasingly concerned about the Federal Government's responsibility to America's elderly to pay adequately for quality care.

A specific point of concern is the role of the hospitals' prospective payment commission in the development of a reimbursement system for skilled nursing care. One consideration is the creation of a comparable commission to meet the mandates of OBRA '90 for skilled nursing care.

The prospective payment system should be driven by Medicare patients' needs. Reimbursement should vary by the type of care provided, not where the care is offered. It is irrational to pay different reimbursement when the same care is provided in freestanding SNFs, hospital-based SNFs, rehabilitation and long term care hospitals, or hospital swing beds.

Furthermore, the differences in length of coverage and patient cost-sharing are as uneven as the much-discussed payment inequities. The two mandates in OBRA '90 for Medicare prospective payment create an opportunity for a provider-neutral "extended care" benefits and reimbursement package.

Manor Care supports the inclusion of return on equity (ROE) in a prospective payment rate, such as proposed in the Chairman's MediPlan Long-Term Care Act (H.R. 651). However, it must be emphasized that eliminating ROE as a specific reimbursable item does not eliminate the need to attract private capital investment. Some Medicaid prospective payment plans use more effective ways to attract needed investment.

For action this year, we have one recommendation for the existing Medicare prospective payment plan -- that is, for facilities with 1500 or fewer patient days. Currently, this prospective payment is further controlled by the ceiling applied under the retrospective cost reimbursement provisions used for the routine service costs for larger providers. The Subcommittee should correct this situation by eliminating the application of the "223" limit on the prospective plan.

Minimum Three-Day Prior Hospitalization

Manor Care supports the elimination of the minimum three-day prior hospitalization as a requirement for skilled nursing care, as proposed in H.R. 1200 by the Chairman and Subcommittee members Moody, Cardin, and Coyne.

The conditions under which most Medicare patients are admitted for skilled nursing care follow an acute care need. Nevertheless, there are some situations in which the patient needs only the SNF level care. For example, this legislation will save Medicare funds and help nursing home patients if their medical condition worsens and they need the more intensive level of service from a Medicare unit. A doctor would not have to place a patient in a hospital for three (far more expensive days) days to allow a qualification for SNF coverage.

The issue for SNF coverage should be whether the high medical eligibility standards are met. Eliminating the minimum three-day requirement would not reduce these standards.

Prior Authorization for SNF Patients

To help patient admissions and simplify Medicare administration, we recommend the Subcommittee authorize a program of prospective authorization for SNF patient stays. As a result of section 9305(k) of COBRA '86, a voluntary program of prior and concurrent authorization is now being demonstrated by HCFA with fiscal intermediaries in Indiana and Tennessee.

Patient access to SNF care would improve tremendously under this approach. Although not heavily used, this patient authorization process would eliminate uncertainty about eligibility in "gray" cases and guarantee coverage when a patient's care needs are substantial. In addition, this administrative reform would reduce the staff time and paperwork required by the present web of retrospective coverage determinations, coverage denial appeals processes, waiver of liability procedures, and demand billing requirements. In exchange, the waiver of liability threshold for SNF care could be reduced from its current 5 percent to 2.5 percent.

* * *

We encourage the Subcommittee's consideration and action on a this set of incremental improvements to Medicare services and administration. As business people, we believe the most responsible approach is to "do what you can as soon as you can." This approach is particularly appropriate when we consider that the world of long term care is fast changing and future challenges are unprecedented.

MASSACHUSETTS MEDICARE ADVOCACY PROJECT
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March 5, 1991

Re: Eliminating Three-day Prior Hospitalization Requirement for Skilled Nursing Facility Placement

The Massachusetts Medicare Advocacy Project represents Medicare beneficiaries who have problems obtaining Medicare coverage. Many of our inquiries concern the Medicare skilled nursing facility (SNF) benefit. It is on their behalf that we wish to enter our comments in support of the bill that will eliminate the three-day prior hospitalization requirement for Medicare SNF admission into the record of the March 4, 1991, hearing.

The current system imposes a hardship on home health beneficiaries who can no longer remain at home and who have SNF but not acute care needs. Many of these beneficiaries come from families which have devoted substantial efforts to maintain the beneficiary at home. Medicare covered SNF care should not be foreclosed from them, absent the necessity for a three day hospitalization, when this is no longer possible.

The current system also encourages nursing homes to hospitalize Medicare beneficiaries for care which could be rendered in the nursing home but for which there is now no possibility of Medicare SNF coverage A nursing home resident who contracts aspiration pneumonia and requires anti-biotic treatment but who has not had a prior qualifying hospitalization provides just one such example. It is certainly more expensive for Medicare to pay for hospitalization in this situation than it would be to pay for the care in a nursing home.

To the extent that there is concern about the costs of this bill based on a fear of how nursing home might "game" the system to their advantage, there are certainly monitoring procedures currently in place that should more than adequately protect against this concern. Specifically, the utilization review and physician certification procedures that are already in place should prevent unscrupulous nursing homes from inappropriately using the elimination of the three-day prior hospitalization requirement to their advantage.

Please do not hesitate to get in touch with us if you wish further information on this bill. On behalf of many Medicare beneficiaries, we encourage you to support its passage.

Thank you.

Diane F. Paulson
Managing Attorney

STATEMENT OF

THE NATIONAL ASSOCIATION OF SOCIAL WORKERS

The National Association of Social Workers (NASW), representing 135,000 professional social workers, wishes to submit the following statement to the hearing record for March 4, 1991. The comments are specific to the role of social work services in the Medicare Home Health Program.

Social work services can make the critical difference between a patient's successful course of treatment in the home and the possibility of rehospitalization or institutionalization. Among those home health patients for whom social work intervention is critical are:

- Patients in need of a skilled assessment of social and emotional factors affecting their illness or treatment plan.
- Patients who have suffered reduced or sudden loss of physical function with impact on treatment management, e.g. CVA, amputation, heart attack, Parkinson's disease, MS acute loss of sight, hearing and speech.
- Patients with terminal illnesses who are experiencing a) severe loss, anger, and/or depression which are impeding treatment; and/or b) family strain and economic difficulties which weaken their support system.
- Patients whose cognitive or behavior problems create difficulty for home management, e.g. Alzheimer's, OBS, organic psychosis.
- Patients with high-tech needs whose families are having difficulty managing their care.
- Patients who have recently encountered a change in caregiver status (e.g. death or sudden hospitalization of a family member) interfering with the treatment plan.
- Patients who need community resources or information to manage short and long term care at home: homemaking, chore housekeeping, financial aid, adult day care, transportation, medical appliances and services, alternative housing, vocational training, friendly visitor, emergency response system, long-term counseling, entitlement programs, assistance with insurance claims, and/or energy assistance.
- Patients in need of nursing home or institutional placement.
- Patients who have marital conflict which creates social problems for themselves and their spouses and which impedes effective treatment.
- Patients at high risk due to any combination of the following: social isolation, decreased mental capacity, lack of informal or formal support systems, unsafe or unstable home environment, suspected neglect or abuse, emotional deprivation, lack of financial resources, or substance abuse.
- Patients in need of advocacy to secure their rights to services and benefits.
- Patients unwilling or unable to follow treatment plan.
- Patients who experience suicidal ideation.

Role of Social Work Services in Home Health Care

The goal of social work services in home health care is to improve or maintain the social, emotional, functional and physical health status of the patient, as well as to enhance the coping skills of the family or other caregiver system. Social work functions in home health include, but are not limited to:

- Skilled assessment of the social, economic, environmental and psycho-emotional factors related to the patient's illness, need for care, response to treatment and adjustment to care; followed by care plan development.
- Counseling for long-range planning and decision-making, including: assessment of the patient's needs for long-term care, evaluation of the home and family situation, enabling patient and family to develop an in-home care system, exploring alternatives to in-home care, when needed, and arrangement for placement.
- Community resource planning, including education, advocacy, referral and linkage to community services.
- Short-term therapy or goal-oriented intervention directed toward: management of terminal illness, reaction and adjustment to illness, strengthening the family support system, and conflict resolution related to the chronicity of illness.

- Crisis intervention and problem resolution associated with high risk indicators endangering a patient's mental and physical health, such as: abuse and neglect, inadequate food or medical supplies, high suicidal potential, or an unsafe environment.

Cost Benefit Implications of Social Work Services in Home Health

Home care social workers are in a unique position of being able to address, and perhaps bridge, the gap between the issues of quality and cost in health care delivery. Too often patients, and particularly the elderly, tend to rely on expensive medical intervention in an attempt to resolve related social and psychological problems. By addressing the psychosocial needs of the patient which interfere with the treatment plan, home care social workers are able to prevent unnecessary medical costs.

- Data suggests that early social work assessment and intervention in home care expedite shorter periods of skilled nursing and other medical services.

- Social work services which address the social and emotional problems which negatively affect the patient's response to treatment increase the patient's ability to stay at home, thus preventing re-hospitalization or other costly institutionalization.

- Social work services which strengthen the family and other support systems, as well as provide a linkage to needed community resources, stabilize the caregiver system and additionally promote recovery in the home.

- Social work services which promote long-term planning allow the patient to continue to act on his or her own behalf, consequently preventing or reducing costly "crisis reactions" by the patient and support system.

Problems Which Interfere with the Effective Provision of Home Care Social Work Services through Medicare

Two primary problems exist which severely impede the effective provision of home care social work services to eligible Medicare patients. These problems limit the availability of needed services to the current population receiving home health care and, if unresolved, promise to affect an even greater population as: 1) the diagnostic related groups (DRG) payment system in Medicare promotes an earlier discharge of hospitalized Medicare patients, and consequently, results in a growing number of Medicare patients requiring home health care; and 2) the growing elderly population demands an increased need for home health services.

1. Home care social work services may only be provided after the opening of a case by a qualifying service (i.e., nursing, speech pathology or physical therapy) and must be terminated prior to the closing of the qualifying service.

The consequences of this restriction affect both beneficiaries and providers.

- This results in fractured services to patients due to social work's delayed entrance into a case and/or premature, and at times, unplanned termination.

- Due to the pressure on home care agencies to limit service, social workers are not always able to facilitate provision of supportive services in the time allowed, or worse yet, referrals for social work intervention are not made at all. As a result, the linkage of patients to entitlements and community resources is often not completed.

- Since homebound patients cannot access community clinics, and community agencies are severely limited in their ability to provide in-home counseling, patients are hospitalized for primarily psychosocial, not medical reasons, thus increasing the costs of their medical care.

- For the isolated, frail elderly, the home health social worker is often the only link to community services. If long-term needs are not met, the patient will not continue to be as independent as possible, and will again require more frequent medical services.

- Qualifying services (particularly nursing) are pressured to postpone the discharge dates of patients to allow social workers to complete their intervention, thus adding additional costs. Conversely, qualifying services are often forced to open cases to allow the social worker to intervene for identified social problems, not medical ones, again adding to the cost. As one nursing administrator of a Florida-based home care agency wrote in response to an NASW survey on home care:

"Our nurses at times have to stretch the case to keep enough 'skill' in the home to enable the social worker enough time to coordinate or finalize community serv-

ices. Often times, the deficit at home is more of a coping or financial problem rather than an actual nursing one. It appears that the insurance carriers have yet to realize that a lot of their costs, i.e., nursing visits and recurrent hospitalizations, could be greatly reduced by social work intervention, with or without ancillary support."

2. State and regional contradictions exist among intermediaries as to what are "legitimate" and, therefore, reimbursable home health social work services.

The lack of clarity and uniformity in the reimbursement of home health social work services under Medicare creates confusion among providers and affects the provision of needed services to home care patients.

- This inconsistent interpretation of reimbursable social work services in home health has led to increased denials for reimbursement of social work activities and to a defensive posture on the part of provider agencies who fear denials. Fearing denials, agencies minimize social work involvement or expect nurses to perform social work tasks.

- Intermediaries have made arbitrary determinations on the types of home health social work services which may be reimbursed by Medicare and, in some parts of the country, have imposed arbitrary limits on the number of visits a social worker may make per home health case (in some cases restricting the visits to as low as 1–2 visits per case). Both severely limit the Medicare beneficiary to services which he/she is entitled.

Recommendations to Resolve the Problems which Interfere with the Provision of Home Care Social Work Services

Resolving the identified problems which interfere with the effective provision of home care social work services will serve to support patients and their caregiver systems who wish to continue health care in the home, as well as to promote the cost effective provision of home health care. The National Association of Social Workers recommends that these problems be resolved by :

1. Granting skilled status to medical social work services under Medicare, thus enabling social work intervention to be a qualifying service in home health.

2. Creating a uniform and consistent system of reimbursement for covered social work services among the fiscal intermediaries that administer the Medicare Home Health Benefit.

Thank you for the opportunity to submit NASW's recommendations for improving the delivery of social work services through the Medicare Home Health Program.

NATIONAL COUNCIL ON THE AGING, INC./NATIONAL INSTITUTE ON ADULT DAYCARE

Testimony submitted by Mary Ann Outwater, NIAD Chair

to the

House Ways and Means Subcommittee on Health

Hearing on Long-Term Care and Proposals for Improving Medicare's

Skilled Nursing Facility and Home Health Benefits

March 15, 1991

The National Institute on Adult Daycare (NIAD) is pleased to submit written testimony endorsed by NCOA on Medicare benefits.

NCOA was founded in 1950 and encompasses nine national constituent units and member organizations that provide services to millions of Americans. NIAD is a national voice for over 2100 adult day care centers.

NIAD commends you for your comprehensive long-term care plan for all Americans and after careful review offer the following recommendations to H.R. 651:

1. Page 41, line 34, (c) medical social services under the direction of a physician (emphasis added). This should read (c) medical social services provided by or under the supervision of a social worker. A physician does not need to supervise medical social services.

2. Beginning on page 41, line 16, the definition of an adult day care program is stated. On page 42, lines 3-8 (C), it says "maintains on the premises and available personnel including at least a physician, a registered professional nurse, social worker, appropriate rehabilitation professionals and (as needed) a dietitian to provide (or supervise the provision of) such services;"

"Maintains on the premises and available personnel" could be interpreted to mean full-time staff. Adult day care centers do not have full-time physicians, rehabilitation therapists or dietitians. They contract as needed for therapies and dietetic services and may use the participant's physician for overall supervision of medical care (not done at the center) or contract for part-time physician consultation. Physician services in adult day care are usually provided by either the participant's private physician or a consultant physician for the adult day care center. This role is similar to a Medical Director and usually does not involve assuming primary care responsibility for the participant. A full-time physician would be very expensive. To clarify the intent that medical services must be available but not necessarily at the center, these changes are recommended:

- Page 42, lines 3-8 (C) Maintains on the premises one registered professional nurse and social worker employed by the agency or organization and has available (as needed) appropriate rehabilitation professionals and (as needed) a dietitian to provide (or supervise the provision of) such services at the center.

- New Section D, line 9, page 42 with remaining sections relettered.

(D) Has procedures for obtaining medical consultation either by liaison with the individual's personal physician or has a physician affiliated with the center.

Additional suggestions:

1. Implement ADC as a Part B Medicare benefit if an incremental approach is preferable to LTC coverage.

Legislation to make ADC a Part B Medicare benefit has been introduced repeatedly in Congress. In the last session, H.R. 990 (Panetta et. al.) and S. 524 (Bradley and Heinz et. al) sponsored legislation to make ADC a Medicare benefit. We expect these bills to be re-introduced in this session. S. 524 established eligibility and service requirements, certification standards developed by the Department of Health and Human Services with consultation from NIAD (our 1990 standards are now available), eligibility determination by state pre-admission or Medicaid long-term care agencies, and surveys by the appropriate state agency. CBO estimates the initial year's costs to be $.1 billion to grow to $1 billion in five years. These costs are offset by savings in other government funds.

Congress has already recognized the increasing importance of adult day centers through the inclusion of adult day care centers as participants in the child care food program of USDA and its mandate for a national adult day care survey in Section 208 of the Catastrophic Care Act of 1988. The report of this survey is pending release by HCFA.

2. Attendance at ADC must <u>not</u> jeopardize the "home-bound" status of Medicare recipients of home health services.

Current policy, HIM-II Section 204.1 (Confined to home) states, "Absences attributable to the need to receive medical treatment includes attendance at adult day care centers to receive medical care." HCFA's fiscal intermediaries in some cases have denied payment for home health care if the person attends ADC on the grounds that the person is not confined to the home, despite the policy statement clearly stating otherwise.

Home Health and ADC may both be needed to maintain a person with functional impairment in the home. Each service has distinct benefits. ADC has treatment benefits that cannot be acheived on a one-to-one basis in the home. For your information, a copy of the NIAD position paper "ADC: A Treatment Program for the Functionally Impaired" is attached. Personal care services by a home health aide can be needed on days when the person is not attending ADC or to help the person get dressed and ready to go to ADC. Coordination between the two services is effective in preventing institutionalizaiton and should be encouraged.

NIAD is interested in working with you in the legislative and implementation process that will make adult day care a covered benefit under H.R. 651. Thank you for your interest and support shown for ADC. Please contact Dianna Porter, Director of Public Policy, 202-479-6613, if you need additional information.

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NATIONAL INSTITUTE ON ADULT DAYCARE

POSITION PAPER

ADULT DAY CARE: A TREATMENT PROGRAM FOR PERSONS WITH FUNCTIONAL IMPAIRMENTS

National Institute on Adult Daycare Position Paper: Adult Day Care: A Treatment Program for Persons with Functional Impairment

Adult Day Care (ADC) is a treatment program for adults who are unable to function independently.

ADC does not cure, but can:

- stabilize medical conditions and avoid frequent hospitalizations
- prevent secondary disabilities that result from excessive bed rest or inactivity
- improve functional ability as a result of sustained maintenance therapy and the therapeutic environment
- improve quality of life for participants and caregivers
- increase self-esteem and dignity of participants
- improve or stabilize cognitive functioning
- increase verbal ability and mobility
- minimize catastrophic reactions such as inappropriate anger, combativeness, suspiciousness, refusal to cooperate and wandering
- provide opportunities for friendships and decrease isolation and loneliness
- improve behavior and mood
- improve nutritional intake

Although the respite function and benefits to caregivers of ADC are often acknowledged, little emphasis has been placed on the treatment aspects. This is due, in part, to a widely held belief that the functional status of persons who have disabilities resulting from chronic conditions is unimprovable. ADC providers challenge this belief. Disability is a function not only of physical change, but of expectations and motivations. ADC's expectations and motivations arise from its origins and are expressed in its philosophy.

ADC programs began development in the early seventies as a grassroots movement. Stimulated by the negative stories about nursing home care and the various studies of inappropriate placement in nursing homes, concerned citizens, committed to a better way, adapted the ADC concept from British day hospitals and psychiatric day treatment programs. Influenced by the holistic emphasis of the time, ADC centers brought health and social services together in an informal setting to meet the needs of persons unable to function independently.

Although a variety of names have been used for adult day care, such as social day care, adult day health care, medical day care and day treatment, the term adult daycare is used here as a generic term to apply to all ADC programs. These programs share a common philosophy:

- Adult day care approaches each person as a unique individual with strengths and weaknesses, yet with a potential for growth and development.
- Adult day care assumes a holistic approach to the individual, recognizing the interrelationship among the physical, social, emotional and environmental aspects of well-being.
- Adult day care promotes positive attitudes toward self-image, restoring, maintaining and stimulating capacities for independence while providing supports for functional limitations.

Key elements of a treatment program are the therapeutic milieu, the interdisciplinary approach, and the range of services provided.

The therapeutic milieu is the philosophy in action. All that occurs in the center takes place with the intent of improving the participants' quality of life. The setting is pleasant, enjoyable and comfortable—more like a living room than an institution. The emphasis is on the positive—there is an expectation and a belief in improvement. Small improvements are applauded and considered to be significant.

ADC offers an individualized blend of support and challenge, designed for each participant based on a interdisciplinary assessment of each person's needs.

All participants in ADC have some limitations in independent functioning. Peer interaction stimulates conversation and the motivation to strive for greater independence. "Small successes" increase dignity and self-esteem.

The atmosphere is warm and caring. Respect, enthusiasm and enjoyment are evident. Stimulation of the mind and body encourages well-being.

Inactivity resulting from pain, weakness, dementia, depression, complications of medications or too much chair or bed rest leads to boredom,

confusion, irritability, insomnia, anorexia and contractures. ADC activates participants in an enjoyable way.

A key treatment ingredient is the interdisciplinary team, representing the health and social services provided by the center. Team members provide individual assessments of medical, functional and psycho-social status, develop a treatment plan in conjunction with the participant and his/her family, and provide services. Realistic achievable goals are set to restore functional independence in as much as possible and slow down further deterioration by on-going maintenance. Team members provide mutual support to each other, and demonstrate patience, perseverance, compassion, along with hope and confidence to motivate participants to actively take part in their treatment.

ADC is a range of services — a continuum of care — stretching from very limited direct services to extensive and intensive medical and therapeutic services. As a participant-driven program, each center must define who they will serve, taking into consideration community needs, availability of staffing and services, and organizational resources. Consequently, centers will vary in the range and intensity of services provided. As participants change, so often do the services provided by the center. Today, many ADC centers are serving persons with severe medical problems and decreasing functional ability by adding appropriate staff to provide needed services and care.

According to the 1989 National Adult Day Care Census, the majority of centers provide nursing, social services, assistance in personal care and mobility, a noon meal, transportation to and from the center, therapeutic recreational, educational and social activities, family counselling, physical, occupational, and speech therapy and medical assessments. Some centers choose to utilize community resources, especially for physical, occupational and speech therapy, rather than directly provide these services. Specialized ADC centers, such as those only serving persons with dementia, may find a different service combination more appropriate for their participants.

Each service makes its special contribution to the therapeutic milieu. However, the interdisciplinary functioning makes the effect greater than the benefits of a particular service. Team members reinforce and support each others' treatment goals.

To illustrate this, one can take each of the treatment outcomes listed above and identify each service's contributions. At first glance, the primary role may seem to be easy. Stabilization of medical conditions and avoiding frequent hospitalization may appear to be the responsibility of the person's physician and center nursing staff. The physician makes the diagnoses, prescribes medication and treatment. Nursing staff administer medication, provide skilled treatment as necessary, health counseling, education, and monitor for compliance and changes. However, the

program aide also contributes through his/her observations while providing personal care to the participant. The dietician contributes by nutritional assessment, while kitchen staff prepares appetizing meals and special diets. Nutritional counselling is provided by the dietician and nurse. Therapies enable the person to function more independently thus decreasing the possibility of secondary disability, while the social worker and the recreation therapist increase self-esteem and improve behavior and mood. The driver, through observation of the home and the participant on the van can add insight to the participant's status.

Improving nutritional intake appears to be a primary contribution of the dietician and the kitchen staff. However, the physician prescribes the diet, therapists work to help the participant be more independent in eating, while the program aide provides assistance in eating if needed. Nurses monitor weight and other vital signs. Through the efforts of the social worker, the participant may be in a better mood and feel more like eating. The enjoyable activities of the recreation therapist also stimulate physical activity and help create appetite. Transportation contributes by bringing the participant to the center.

The program director contributes to treatment goals by setting the tone of the center's atmosphere, providing direction and support to team members in carrying out their work, and enabling the team to function creatively and effectively.

In summary, as the two examples demonstrate, every team member contributes to each of the treatment outcomes in varying ways, depending on the special expertise of their function.

Even if all these services are not available at the ADC center, the therapeutic milieu, which is independent of any particular service, encourages and reinforces functional gains as well as providing socialization and recreation for the person with the impairments and respite, counseling and support for family caregivers.

Today there are approximately 2,100 ADC centers located in all fifty states providing treatment to participants and enhancing the quality of their lives and the lives of family members who may be providing care.

ADC has brought a new vocabulary and a broader meaning to familiar terms like treatment and rehabilitation. Persons receiving services are participants, not clients or patients. "Participant" expresses a respect for the individual and an acknowledgement that the person is an active partner, not just a person receiving care. All too often, home and institutional care is designed solely to meet the needs of persons who can not care for themselves. This is not enough. The attitude of the service provider plays a significant role in the outcome. ADC providers have a positive attitude and expectation of improvement that instills hope in the participant. Motivated by the therapeutic milieu, encouraged and stimulated by their peers, participants often do achieve those "small successes" which add so

much to the participant's self-esteem and quality of life. ADC stimulates capacities for independence while providing the support needed for functional limitations.

The accomplishments of ADC indicate the inadequacy of current theories about disabilities caused by chronic or degenerating mental or physical conditions and short-term rehabilitation, particularly concerning the elderly, and the importance of the holistic approach. If there are family caregivers, they also benefit, not only by having relief from caregiving during ADC hours, but also by the treatment they receive, such as emotional support and counseling. They also benefit from the participant's improved behavior and mood. Persons who have increased self-esteem, meaningful activity and who feel that they matter to others, make the caregiver's tasks easier.

Statement of Marie-Louise Ansak
Executive Director, On Lok, Inc.
for Long-Term Care and Proposals to Improve Medicare's
Skilled Nursing Home Facility and
Home Health Benefits

United States House of Representatives
Subcommittee on Health, Committee for Ways and Means
Hearing March 4, 1991

I commend you for your recognition that the need for long-term care is well-documented. A national strategy to address the substantial needs of chronically ill individuals is long overdue.

To help you in developing your strategy, it is important that you know about a successful comprehensive long-term care service and delivery model, On Lok Senior Health Services, and its replication project, Program of All-inclusive Care for the Elderly (PACE).

Since 1983, On Lok of San Francisco, California has operated successfully as a waiver demonstration program under federal law. With capitation funding from Medicare, Medicaid and the private individual, the program provides comprehensive medical and social services to a very frail nursing home certified eligible elderly population. With capitation funding, On Lok gained freedom from the traditional fee for service or diagnosis-related groups reimbursement systems and their requirements, becoming the first provider to assume full financial risk for the total health care of an impaired long-term care population.

In 1985, having evaluated On Lok's services and cost effectiveness, Congress made On Lok's demonstration a permanent program allowing its waivers to remain in effect as long as the program operates successfully. In 1986, Congress passed legislation authorizing up to ten publication non-profit community-based organizations to replicate On Lok's model under similar waivers and capitation. The Budget Reconciliation Act of 1990 has increased the number of such sites to 15.

The PACE project is the first nation-wide demonstration to test the transferability of the managed care, integrated service and financing system developed by On Lok to other settings.

For the past 15 years, the emphasis has been on a separation of long-term care from acute care. Case management and enhanced funding for non-medical support services have been utilized in many Medicaid or Medicare demonstration projects, the most recent being the National Channeling projects. Such projects usually were unable to influence wither the utilization or costs of existing covered services to balance the increased cost of case management and additional supportive services.

Policy analysts and researchers have begun to recognize that utilization of medical services can only be controlled in an integrated acute and long-term care system.

Conclusions stated by Researchers John Capitman and Winnie Hernandez, National Aging Resource Center for Long-Term Care, Brandeis University are:

"Two broad conclusions have been drawn from research on community care: a) increased financing for community LTC may be desirable but will not significantly reduce the growth of Medicaid expenditure; (b) community long-term care as now offered can change use patterns for some disabled and socially isolated persons, but for much of the diverse long-term care population, effective treatment requires multidisciplinary practice and integrated medical and supportive service delivery systems." (emphasis added) (Capitman and Hernandez, The Aging Network and the Challenges of the 1990s, Emergency Issues in Long-Term Care, Brandeis U., 1990)

According to Carole Estis, Director, Institute for Health and Aging, University of California, San Francisco, "Ultimately, a consolidated delivery model, in which services are provided by a single organization, needs to be developed to cut costs and eliminate the false and unproductive dichotomy between acute and long-term care services." (Estis, Perspective on Aging, Long-Term Care Is Mainstream. Why Isolate it from Acute Care?, July-August 1990)

Although services and funding have been integrated in prepaid health plans and health maintenance organization, these principles have generally not been applied to a long-term care population. No other program has attempted complete long-term care and service capitation. Medicare Health Maintenance Organizations cover primarily acute care services, while the Social Health Maintenance Organizations provide a limited long-term care coverage for a limited percentage of their enrollees.

Currently four PACE projects are operating under the same waivers as On Lok does, with four more expected to begin in late 1991. Others are involved in the planning and development phase.

Under waivers:

- Elder Service Plan, East Boston, MA
- Providence ElderPlace, Portland, OR
- Palmetto SeniorCare, Columbia, SC
- Community Care for the Elderly, Milwaukee, WI

To begin in 1991:

- Bienvivir Senior Health Services, El Paso, TX
- Comprehensive Care Management, Bronx, NY
- Total LongTerm Care, Inc., Denver, CO
- Umoja Care, Inc., Chicago, IL

HR 651 Mediplan Long-Term Care Act of 1991 provides universal coverage of long-term health care for the chronically ill individual via home, community and nursing facility services in a new Title XXII of the Social Security Act.

However, it does not allow a consolidated model such as PACE to participate. There are two issues I want to bring to your attention:

Section 2102 (d)(1)(A) allows case management services to be provided by a private nonprofit entity, peer review organization, health maintenance organization or other entity which does not (emphasis added) provide nursing facility services or long-term home and community-based care. In the consolidated model used by On Lok Senior Health Services and its replication program authorized by Congress, Program of All-inclusive Care for the Elderly (PACE) assessment, service provision and case management are done by the multidisciplinary teams of our adult day health care centers. Upon enrollment an initial assessment is done, an assessment summary and

a plan of care developed and sent to our Regional Medi-Cal field office for level of care determination. All enrollees must be over 55 years, live in our service area (Chinatown-North Beach-Polk Gulch) and be eligible for intermediate or skilled nursing home care. We utilize the financing principles of a HMO for a population that are, by definition, users of services. We are capitated by Medi-Cal and Medicare and at risk. Case management and assessment are an integral part of our service provision and allow for close monitoring and rapid response to changes in health status. To superimpose an assessment and case management agency over us would be costly, cumbersome and would lower the quality of care. We provide the full range of acute and long-term medical care, health and health-related services needed by our very frail population.

I understand your intent in assigning an objective third party to make level of care and service utilization decisions for providers of individual service components. However, a capitation rate achieves the same objective of cost containment and program eligibility is determined the state, a neutral, third party in our model.

Separating out case management is adding an additional and unnecessary cost for capitated PACE providers. I ask that your legislation add after "such an agency may be (page 18, line 17) programs established under Section 603 PL 28-21 Section 986 of OBRA of 1985; Section 9412 of OBRA of 1986 and Section 4118 (g)(1) and (2) of the OBRA Act of 1987 and the Budget Reconciliation Act of 1990. A private nonprofit entity, peer review organization, health maintenance organization or other entity which does not provide long-term home and community-based care may also be an assessment and case management agency. The sections cited authorized the On Lok project, its continuation and the replication project, PACE.

2) My second issue relates to our combination of all acute and medical care for a nursing home eligible population. We would be providers for the long-term care benefits as well as the Mediplan Health Benefits which are now in a separate bill.

It is not clear that our consolidated model can be a provider of Mediplan health and long-term care benefits. Clarification regarding the eligibility of On Lok and PACE needs to be made in both bills.

The On Lok model or PACE is one of few models that has shown its ability both to maintain very disabled elders in the community and at the same time save money over what it would cost to institutionalize them.

Such a model must be included in a national long-term care strategy.

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